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LIVED EXPERIENCES OF MEN IN NURSING: CHICKADEES, STEPPING
STONES, AND MUDDLING THROUGH MATERNITY

by

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Bachelor of Science, Mary College, 1980

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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota

December

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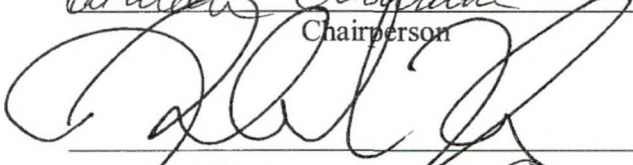
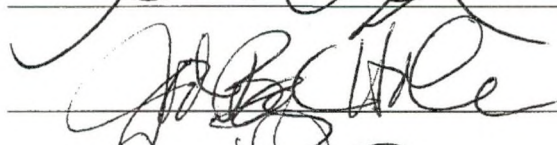
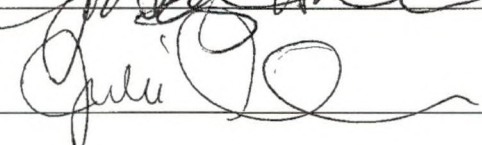
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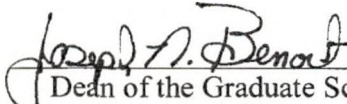
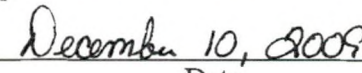
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ABSTRACT

The profession of nursing is facing an imminent shortage of health care providers within its discipline. Registered Nurses comprise the largest group of health care professionals in the United States. The profession of nursing has experienced cycles of worker shortages in the past but this current situation is predicted to be unlike previous shortages. Efforts to alleviate previous nurse shortages focused primarily on efforts to glorify the feminine image of nursing to increase the recruitment of young women into the profession but the profession can no longer rely on an unlimited supply of women to become nurses because of an increased competition with other professions. Nursing needs to change its focus and recruitment strategies from that of white, relatively young, unmarried women to candidates who are from ethnic minorities, individuals embarking on a second career, other health care workers and men to fill present and future vacancies. In order to make gains to the profession with recruitment efforts, retention strategies must also be addressed. Currently, men constitute nearly six percent of the total number of registered nurses in the workforce and this percentage has varied very little over many years.

The purpose of this study was to understand the experiences of male nurses who practiced in various roles that included the provision of direct patient care using the phenomenological research paradigm. The sample for this study consisted of twelve male registered nurses. One-on-one interviews were conducted utilizing a semi-structured guide.

Categories identified from the data were societal stereotypes, women's work, working with women, vulnerability, entitlement, and career satisfaction. The final assertion for this study was: The men in this study displayed strength, persistence, and perseverance to make the decision to become nurses; to finish their education in a timely manner; and to carve out a niche that has given them job satisfaction while maintaining a sense of superiority to work as professional registered nurses. Strategies for the recruitment and retention were developed from this study. The information obtained can be used to formulate further studies to help develop strategies to ease the present and the predicted impending nursing shortages.

CHAPTER I

INTRODUCTION

Registered nurses comprise the largest group of health care professionals in the United States. The number of the members of the nursing profession in this country hit an all time high of 2.9 million in 2004 after an approximate eight percent growth between 2000 and 2004 (United States Department of Health and Human Services Health Resources and Services Administration [HRSA], 2004). The occupation of registered nurse was listed as one of 30 occupations with the largest job growth in 2008 (United States Department of Labor Women's Bureau, 2008a).

Despite recent positive reports about the increase in numbers and in the growth of the occupation of nursing, the present day profession of nursing is experiencing a national nursing shortage. The current national nursing shortage began in 1998 and peaked in 2001 when there were an estimated 126,000 registered nurse hospital vacancies. The current shortage became the longest national nursing shortage in the past fifty years when it entered its eighth year in 2005 (American Hospital Association [AHA], 2001; Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005; Buerhaus, Staiger, & Auerbach, 2000b). There is no end in sight for the current nursing shortage and by 2020 the estimated deficiency of registered nurses is projected to be 340,000. This proposed shortfall in the number of registered nurses by 2020 is lower than the previous forecast of a shortage of approximately 760,000 nurses by 2020 that was predicted in an earlier study conducted by the same researchers (Auerbach, Buerhaus, & Staiger, 2007).

The significant decrease in the projected number of registered nurses vacancies by 2020 should not provide any type of encouragement for health care consumers.

Researchers have noted that a shortage of 340,000 registered nurses is three times larger than the size of the current nursing shortage when it was at its peak in 2001. In 2001, the national hospital registered nurse vacancy rate was 13% and many hospitals were forced to close patient programs and nursing units at that time (AHA, 2001; Auerbach et al., 2007). Buerhaus, Auerbach, and Staiger (2009) revised these earlier predictions based on new survey data that did show improvement in registered nurse numbers to forecast that the magnitude of the 2025 nursing deficit will still be more than twice as large as any nurse shortage experienced since the introduction of Medicare and Medicaid in the mid-1960s.

The revised nursing shortage forecasts predict an imminent shortage of health care providers that continues to pose a serious threat to access and efforts to improve the quality and safety of health care (Auerbach et al., 2007; Buerhaus et al., 2009; Clarke & Donaldson, 2008). Studies have been recently initiated to investigate the impact of registered nurses in the provision of safe patient care. Research addressing this topic was very limited prior to 1996. Clarke and Donaldson examined research studies were conducted to determine the impact of nurse staffing in hospitals and other health care organizations on patient care quality as well as safety-focused outcomes. The general conclusions from this review of those research studies were that differences in outcomes were often observed between situations or institutions where staffing was high and those where it was low. These authors concluded that the data revealed that staffing at the lower end of this spectrum may place patients and nurses at higher risk of poor outcomes.

An example of one research study regarding the impact of nurse staffing on patient safety was conducted by Aiken, Clarke, Sloane, Sochalski, and Silber in 2002. The research data that was obtained from that study revealed that hospitals that had high patient-to-nurse ratios, surgical patients experienced higher mortality and failure-to-rescue rates. The nurses who worked in those settings were more likely to experience burnout and job dissatisfaction. The researchers suggested that nurses who provide around-the-clock surveillance contribute importantly to the early detection and timely interventions that saved lives when patients' conditions deteriorated. The effectiveness of the nurse surveillance was influenced by the number of registered nurses available to assess patients on an ongoing basis. It was also concluded that improved registered nurse staffing levels could help alleviate the nursing shortage by decreasing burnout and job dissatisfaction that contributed to staff turnover. Clarke and Donaldson also noted that some previous research studies addressed the level of education of nursing staff and patient safety. An example of one of these research studies was conducted by Aiken, Clarke, Cheung, Sloane, and Silber in 2003. This study regarding patient safety documented significantly better patient outcomes in hospitals that had staffing patterns of more highly educated registered nurses who were prepared at the baccalaureate degree or higher levels who gave bedside care. The researchers suggested that hospitals needed to recruit and retain baccalaureate-prepared nurses and to invest in further education for all nurses to make substantial improvements in the quality of care delivered to patients.

The profession of nursing has experienced cycles of worker shortages in the past but the current situation is predicted to be unlike previous shortages. Previous efforts to alleviate nurse shortages focused primarily on efforts to glorify the feminine image of

nursing to increase the recruitment of young women into the profession. Research studies have shown that the profession could no longer rely on an unlimited supply of women to become nurses because of an increased competition with other professions (O'Lynn, 2004). Prior to the current shortage, a national nursing shortage occurred from 1990 to 1992. At the conclusion of this short-lived shortage, it was predicted that the demand and supply of registered nurses would be in balance for the foreseeable future and that there would be a possible oversupply of nurses in the near future (Buerhaus et al., 2005; Pew Health Professions Commission, 1995). Those predictions of an oversupply of nurses in the future were refuted within six years after they were published when the current nursing shortage ensued.

Researchers have utilized data from various sources including national registered nurse surveys and census surveys to examine trends, to formulate predictions, and to generate recommendations for the nursing profession. One survey that is commonly utilized for these purposes is the National Sample Survey of Registered Nurses that has been conducted by the United States Department of Health and Human Services every four years since 1980. The 2000 survey results from this agency analyzed the increase of the registered nurse population from 1980-2000 in four year increments and reported that the years between 1996 and 2000 marked the slowest growth in numbers for that population. The report of the survey that was conducted in 2000 revealed that the decreased numbers of registered nurses reflected fewer new entrants to the nurse population as well as a larger volume of losses from the nurse population than in earlier years. Most of the increase in the registered nurse population between 1996 and 2000 was the growth in the minority nurse population. This survey also documented the continuing

trend in the aging registered nurse population. In 1980, 25.1 % of registered nurses were under the age of 30 and in 2000 this age group comprised 9.1 % of the nursing population. The change in these percentages in this age group indicated that the registered nurse population was aging (Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000).

Buerhaus, Staiger, and Auerbach (2000a) asserted that the primary factor that led to the aging of the registered nurse workforce appeared to be a decline in the number of younger women who chose to enter the profession the last two decades of the 20th century. These researchers predicted that by the year 2010 more than 40% of the average age of the registered nurse workforce would be over the age of fifty and that the total number of full-time equivalent registered nurses per capita would peak around the year 2007. A steady decline in the number of nurses was predicted to occur after this time as large numbers of registered nurses who were born in the 1950s begin to reach retirement age.

There have been a number of research studies that have provided additional factors that have contributed to the current nursing shortage. Some of these factors that have been cited include the changing population demographics and health needs, decreased nursing school enrollment of people born in the 1970s, increased career opportunities for women, changes in the healthcare delivery system, deteriorating working conditions, nurse burn-out, and the public's misunderstanding of what nurses do (Buerhaus et al. 2000a; Lerner, D'Agostino, Musolino, & Malspeis, 1994; Murray, 2002).

Researchers also predicted that the demand for nurses would increase because of social and economic trends that were expected to affect the healthcare delivery system in the future. Examples of those trends included the aging of the population, an increase in

the sophistication and complexity in technologies and services, an increased demand for registered nurse services, a competitive work environment among acute care facilities, changes in employees' work ethics, the influence of Generation X and dot.com workers, and the increase in the health/wellness movement (Lerner et al., 1994; Murray, 2002).

The results of the 2004 National Sample Survey of Registered Nurses yielded important information about the profession of nursing and reevaluation of predictions about the nursing shortage. The data from this survey showed that the number of licensed registered nurses grew by almost 8 % between 2000 and 2004 and the average age of the registered nurses continued to climb to an average age of 46.8 years. Eight percent of the registered nurses were under the age of 30 in the 2004 survey. This population decreased from 9.1 % in 2000 (United States Department of Health and Human Services HRSA, 2004). The significant increase in the number of registered nurses between the years of 2000 to 2004 was not from the age group of persons who traditionally enrolled in nursing education after high school graduation. The data from this survey revealed that the number of people who entered nursing in their early to mid-twenties remained at its lowest point in 40 years. The encouraging news was that the data revealed that many people entered the profession in their late twenties and early thirties at almost the same rate of the large cohort groups in the 1950s who presently constitute the majority of the nursing population. The shift to late entry nurses, in addition of a large number of nurses, who were considered "nontraditional", significantly strengthened the nursing population between the years of 2000 to 2004. The predictions regarding the deficit in the nursing positions by 2020 decreased but the deficit still remained at a critical level (Auerbach et

al., 2007; Buerhaus et al., 2009; United States Department of Health and Human Services, HRSA).

Context of the Problem

Statistical reports from various government agencies vary slightly as to the number of registered nurses in this country but the common findings among these reports are that large numbers of women are employed as registered nurses and that females comprise the vast majority of the registered nurse workforce. The United States Department of Labor Women's Bureau (2008b) reported that there were 2,548,000 women who were registered nurses in the United States in 2008. The occupation of registered nurse ranked second in the top ten prevalent occupations for employed women that year. Another report issued by The United States Department of Labor Women's Bureau (2008c) described that females comprised 91.7 % or 2,548,000 of the 2,778,000 persons employed as registered nurses in 2008. The statistical results from this report showed an increase in the registered nurse population who were employed, an increase in the number of women who worked as registered nurses and a slight decrease in the percentage of men working as registered nurses in 2008 when compared to the 2006 survey results that were published by that same government agency. In 2006, 91.3 % or 2,309,000 of the 2,529,000 persons employed as registered nurses were women (United States Department of Labor Women's Bureau, 2006).

The United States Department of Health and Human Services HRSA (2004) reported that there were 168, 181 men who comprised 5.8 % of the total registered nurse population of 2,909,357. This agency's survey results also described that the population of nurses who were males had an increase of 273.2 % over 1980 when the number of men

who were nurses was estimated at 45,060 or 2.7 % of the registered nurse population (Spratley et al., 2000; United States Department of Health and Human Services HRSA).

The demographics of the ratios of the nursing population by sex do not reflect the proportion of women and men in the general population of the country. Concerns have been voiced about the disproportionate ratio of females and males employed in the nursing population. Advocates have stated that the nursing workforce should reflect the racial, ethnic, and gender characteristics of the population that it serves. It has been hypothesized that successful recruitment of males into the profession of nursing could not only increase the number of nurses in the workforce but would also increase the diversity of the profession's workforce (Brady & Sherrod, 2003).

Government agencies, researchers, marketers, schools, nursing educators, employers and policy makers with private and public funding sources need to take a more active interest in nurses' careers specifically in the areas of recruitment and retention. Recruitment efforts need to look beyond the shrinking traditional pool of eighteen-year-old female high school graduates who customarily enrolled in nursing programs prior to the 1980s.

Recommendations for changes in recruitment practices have been formulated and there have been several options proposed to help alleviate the nursing shortage (Lerner et al., 1994). One proposed recruitment option, to help ease the nursing shortage, was to locate new sources of registered nurses from non-traditional groups. The implementation of this strategy implied that the base of nursing needed to be expanded beyond the typical registered nurse who was a white, relatively young, unmarried woman and by locating candidates who were ethnic minorities, individuals who were going to embark on a

second career, other health care workers, or men to fill the present and future nursing vacancies (Lerner et al; O'Lynn, 2004). Statistical reports that reveal the unequal percentage of nurses who are female to nurses who are male in the workforce confirm opinions that if the same number of men entered the profession of nursing at the same rate as women, there would be no current nursing shortage. More men tend to work full time than women and it has been cited that if one third of the nursing workforce was composed of males, there would be workplace stability and there would be a surplus of nurses (Pittman, 2005). It also has been noted that men and Hispanics, who are currently underrepresented in the current nursing population, could add enough new registered nurses into the workforce to avoid the projected deficit through 2025 (Buerhaus et al., 2009).

Traditionally, recruitment of new groups into the ranks of professional nursing has been slow and very few nursing schools have done anything tangible to recruit male students (Lerner et al., 1994; Weber, 2008). Career counselors have been of no assistance or do not readily recommend or encourage the female dominated nursing profession to males in the high school setting (Kelly, Shoemaker, & Steele, 1996; Meadus & Twomey, 2007; Whittock & Leonard, 2003; Williams, R., 1973). LaRocco (2007) asserted that guidance counselors routinely discourage intelligent students from choosing nursing as a career. Some nursing education settings have had a strong history of discouraging men from entering the profession and some institutions have not encouraged males to enter the profession by issuing recruiting materials that reinforce the societal stereotype that nurses are women (Lerner et al.; Weber).

Retention efforts for nurses who are both male and female by nursing schools and nurse employers will need to follow recruitment efforts so that there would be an overall gain to the profession (Brady & Sherrod, 2003; O'Lynn, 2004). It has been reported from a 2000 National Sample Survey that males resigned from the nursing profession four times more frequently than nurses who were female during the first four years after graduation (Sochalski, 2002; Spratley et al., 2000). Egeland and Brown (1989) described that 10 % of the men interviewed in their research study stated that they would not be working as nurses in five years. Aiken, Clarke, Sloane, Sochalski, Busse, Clark, et al. (2001) reported that 20 % of all nurses in the United States planned on leaving their jobs in the next year.

Statement of the Problem

The problem statement for this study was: What were the life experiences and perceptions of the profession of nursing of a selected sample of male nurses who have worked in various roles that included the provision of direct patient care?

The Purpose of the Research

The purpose of this study was to describe and explore the lived experience of a sample of nurses who were male and practiced in various nursing roles that included the provision of direct patient care. This research study was conducted to gain insight into perspectives of male nurses because there was very little research published regarding career perceptions of this minority population within the nursing profession. The information obtained from this study can raise the awareness of nurse educators and nurse administrators regarding rewards and challenges that nurses who are male commonly face while entering and working in this predominantly single sex profession

(Williams, C., 1992). The awareness of perceived rewards and challenges obtained from the data from this study can serve as a stimulus for the formulation of strategies to enhance both the recruitment and the retention of males in the profession of nursing. These strategies, in addition to other staffing innovations that have a focus to help solve this impending staffing crisis, can help to ease the projected nursing shortage. Meadus (2000) stated that the development and the implementation of recruitment and retention strategies was crucial to help the profession of nursing survive the 21st century.

The Research Question

The central question for this research study was: What were the life experiences of male nurses who worked in various roles that included the provision of direct patient care as professional nurses? Participants were asked to share their lived experiences about the process of choosing nursing as a career, their nursing education experiences, their professional work experiences, and evaluation of their career choice in the female dominated profession of nursing.

Limitations of the Study

Interviewees for this study were limited to registered nurses who were male and had the minimum academic preparation of a baccalaureate degree in nursing. The acquisition of the sample for the study was geographically limited to include male nurses who resided in the central portion of a conservative Midwestern state that had a relatively small homogeneous population. The study sample consisted of nurses who worked in various roles that included the delivery of direct patient care in a variety of hospital nursing practice settings and were not in the process of pursuing additional advanced graduate education as nurse anesthetists or as nurse practitioners at the time of the

interviews. Sochalski (2002) conducted an analysis of the 2000 National Sample Surveys of Registered Nurses and concluded that one of every three staff nurses were dissatisfied with their current jobs in 2000 and that the employment area of hospital was the site of highest overall dissatisfaction (Spratley et al., 2000). Data received from this population who provided direct patient care as part of their various jobs in acute care settings was deemed to be a valuable source of information because the shortage of this type of caregiver has been predicted to occur as the profession of nursing faces its present and impending future imminent crucial work force shortages.

Delimitations of the Study

The number of interviewees for this study was deemed to be no fewer than twelve male registered nurses who had a minimum of six months of experience of providing direct patient care as registered nurses. The interview process was continued until data saturation was reached. The first interviewees for the study were selected because of professional association with the researcher who worked in a medical center setting as a nursing practice instructor and subsequent interviewees were located through the process of snowball sampling.

CHAPTER II

LITERATURE REVIEW

This chapter contains the review of literature. This literature review is divided into eight sections: The Invisible Caregivers in the Historical Archives of Nursing, Women's Work, Men Who Choose to Enter the Profession of Nursing, The Nature of Nursing Curricula, Differences in Communication and the Processing of Knowledge Between Males and Females, Challenges of Males Enrolled in Nursing Education Programs, Males Who Are Nurses in the Workplace Setting, and Challenges of Patient Care Encountered by Nursing Students and Registered Nurses Who are Male.

The Invisible Caregivers in the Historical Archives of Nursing

The vast majority of nursing textbooks credit Florence Nightingale for beginning the profession of nursing during the mid 1850s when in fact, the foundations of the nursing profession have been present since the beginning of time when men and women tended to the sick. The overwhelming majority of professional nurses and the members of the general public lack the awareness that the first nurses actually were males and that men have been a vital part of the nursing profession since its origin (Bartfay, 1996; Kalisch & Kalisch, 1978). These incomplete presentations of nursing history contribute to the perception that nursing is a female profession in which the role of men is limited (Anthony, 2004).

Early History

People who lived in ancient civilizations believed that angry gods and evil spirits caused illness and disease. These beliefs led the healing practices at that time to assume a religious tone (Donahue, 1996; Kalisch & Kalisch, 1978). Care giving in some of the earliest civilizations was closely tied to religious worship and it was a role that was assumed by male priests and their male assistants who provided care through incantations, administration of herbal remedies, and the offering of care and comfort to their patients. Men assumed the role of caregivers in ancient societies such as Persia and Babylon (Anthony, 2004).

Writings attributed to Moses that are contained in the Old Testament of the Bible provided hygienic guidance to the Jewish people in religious terms. Passages from the Bible in Deuteronomy 14:1-21 and Leviticus Chapters 11-15 addressed personal, family, and national hygiene that were directed toward the maintenance of health and the prolongation of life for the Jewish people. Jewish priests acted as health inspectors in addition to providing religious duties (Barker, 2002; Mellish, 1990; Nutting & Dock, 1907/1974).

The first known trained individuals to provide nursing care were men who were supervised by male physicians during the Hippocratic period of ancient Greece. Hippocrates, who is known as the father of medicine, utilized males to assist him with his work. These assistants were always men because of that society's restriction of women's roles to the home (Bartfay, 1996; Brown & Stones, 1973; Kalisch & Kalisch, 1978).

Public hospitals were developed in India around 275 B. C. E. and nursing care was differentiated from medical care at that time. Men who served as nurses provided

patient care and the physicians treated wounds and performed surgery. The Hindus started the first known formal school of nursing in India in about 250 B.C. E. Admission to that school was restricted solely to men because women were not considered to be pure enough to serve in that role (Anthony, 2004; Bartfay, 1996; Pittman, 2005).

In Ancient Rome the best nursing care was given to soldiers in military hospitals by male attendants (Donahue, 1996). Military religious orders were formed during the Crusades where members performed dual roles to fight as soldiers and to also provide care to knights and other pilgrims making the journey to the Holy Land. The Knights Hospitallers of St. John of Jerusalem and the Teutonic Knights were composed of men who nursed the sick and injured when they were not on the battlefield (Anthony, 2004).

Throughout the early Christian Era, the early Christian hospitals were started and the sick were tended by monks and nuns who served as nurses. The delivery of nursing care to the sick and to the poor by the early Christians was associated with Christian teachings and epitomized the concept of altruism that was associated with the church. Nursing was seen as a calling that could be done by those who renounced the world, demonstrated self-sacrifice, and had an intense religious motive. In eastern Rome the members of the Parabolani Brotherhood risked their own lives by searching for needy sick plague victims to bring to hospitals for treatment. The members of this brotherhood also acted as bodyguards for the bishop and buried the dead (Donahue, 1996).

Religious persons who provided nursing care in the early Christian hospitals were later replaced by congregational members. This replacement process was nearly complete by the 6th century. Nursing then became a separate and specialized occupation at that time. Most of the nurses were men but women staffed the female wards in the Byzantine

or Eastern Roman Empire hospitals. Nurses, both male and female, were eligible to join guilds and earn an equal wage in that region of the world. The predominant male members of those nursing guilds received basic education and professional training and had to pass an examination in order to work as nurses (Bullough, 1994a).

The nursing guilds that were formed in the eastern Mediterranean region were not widely used in the western Mediterranean region because of the domination by men and women affiliated with religious orders as nurses in that area of the world. The western monks and nuns adhered to the ideas of St. Benedict that emphasized intellectual useful work as part of their religious obligations (Nutting & Dock, 1907/1974). St. Benedict decreed that every monastery have a hospital to attend to the needs of the members of the order and to the workers on church-owned estates (Kalisch & Kalisch, 1978). Nursing of the sick eventually became a chief function and duty of Benedictine community life. The Benedictines followed Chapter 36:1 of the Rule of Benedict that mandated "Care of the sick must rank above and before all else, so that they may truly be served as Christ" (Fry, 1980, p. 59). The members of that religious community possessed the highest degree of practical medical skill with understanding for that period in history especially in the areas of medical and surgical relief (Nutting & Dock).

Guilds were formed for surgeons, apothecaries and barbers in the western Mediterranean area of the world (Bullough, 1994a). Barbers at that time were utilized to perform bleeding, extract teeth, and dress boils, bruises, and open wounds (Nutting & Dock, 1907/1974). Physicians developed a university structure to provide education for members of their profession but no similar programs were developed for nursing.

Nursing was seen as an occupation for those who chose religious lives through the first half of the 19th century (Bullough, 1994a).

Hospitals were built near churches and abbeys in early England. This placement of infirmaries beside religious orders was also seen in other parts of the world. Male military and nonmilitary nursing orders flourished during the Middle Ages and the Renaissance (Mellish, 1990).

The Dark Ages of Nursing

The years between 1500 and 1800 are commonly referred to as the “dark ages” for nursing as the profession experienced a decline in its knowledge base, values and status in many Western locales (Mellish, 1990). This decline in the nursing profession was in direct contrast to the field of medicine that made notable advances during that same time (Mellish; Nutting & Dock, 1907/1974).

The Dark Ages that extended through the in middle of the 19th century was an era of stagnation with no elevations in nursing knowledge or the improvement in the conditions of hospitals (Mellish, 1990; Nutting & Dock, 1907/1974). A primary factor for that decline was the massive closings of monasteries and convents related to the Protestant Reformation. The monks and nuns who were driven out of the northern European countries took their nursing knowledge and literature with them. Many hospitals were turned over to secular organizations that often employed untrained nurses who were of questionable character because there were no qualified people to take care of the sick and the poor. Many women at this time were assigned nursing duties in lieu of serving jail sentences. The control of nursing was then taken over by men who were civil appointees that assumed leadership of the hospitals. The immoral, drunken, and illiterate

women who were acting as nurses delivering direct patient care had no input to their work conditions (Donahue, 1996; Mellish). Nurses who voluntarily became nurses were assumed to have entered nursing because of their inability to be accepted for employment anywhere including prostitution (Mackintosh, 1997; Mellish). Men who worked as nurses or orderlies at that time had a reputation for drunkenness and incompetence (Pittman, 2005). Nurses during that period of time were known to cheat their employers, trick their patients, and to steal their patients' rations of food and possessions. Those nurses demanded that their patients pay for extra little services and were commonly cruel to the sick that were at their mercy. Hospitals became places of horror and the unsanitary conditions in these institutions led to outbreaks of epidemics. Those institutions resembled crowded prisons.

Substandard nursing care and unsanitary conditions were prevalent during that time were present in American hospitals. The occupation of nursing was not subject to inspection or discipline (Kalisch & Kalisch, 1978). One in three surgical patients died from sepsis obtained from hospital settings. Perfume was sprayed in the patients' wards because of intolerable stench and nurses adopted the use of snuff to make working conditions more tolerable by masking smells. Some of the "nurses" could not read directions on medicine bottles and administered fatal doses of medications to patients. Patients who were admitted to Philadelphia General Hospital during a cholera outbreak in 1832 were cared for by attendants who were continuously intoxicated. In drunken states, the attendants fought over the beds of the sick or laid in a stupor beside dead bodies (Donahue, 1996; Kalisch & Kalisch). In countries where the religious sisterhoods

continued to exist the standards of nursing care did not fall as low in the institutions that they controlled (Mellish, 1990).

The majority of nurses throughout history were men until the mid 1800s and at that time there are three social changes that then influenced the shift of the majority of this profession to the female sex. These social changes included the decrease in the number of monasteries and male nursing orders and the increase in the number of convents and female nursing orders that began during the Renaissance. Women then began to replace men as nurses in many Catholic hospitals at that time. The provision of nursing care became undisciplined and was of poor quality in the secular hospitals. The status, respect, and pay of nurses plummeted in northern Europe and former English colonies. Hospital nursing staff commonly consisted of social misfits, alcoholics, prisoners, or prostitutes (Donahue, 1996).

The most significant factor that affected the present distribution of sex within the profession of nursing was the Industrial Revolution that began with the building of numerous factories and growth in industries that extracted natural resources. This work excluded women because of the heavy labor and the long hours away from home. Men chose to get those jobs because these jobs paid high wages and required no formal education (Christman, 1988b; Donahue, 1996).

The modern medical profession was born in 1858 when the Medical (Registration) Act was passed in England and the previously unrelated order of medical practitioners of physicians, surgeons, apothecaries, and general practitioners became unified. The alliance of these occupations started a male monopoly in health care (Witz, 1992).

The Dawn of Modern Nursing

In the mid 19th century Florence Nightingale became known for her success in improving conditions in the battlefield hospitals in Crimea and India. The upgrading of patient care conditions in those remote military settings gave her the political respect and authority to reform squalid conditions of the hospitals in England (Donahue, 1996; Kalisch & Kalisch, 1978).

Florence Nightingale received nurses' training for three months in 1851 at the Deaconess Institute at Kaiserwerth, Germany that was established by Pastor Theodor Fliedner (Donahue, 1996; Kalisch & Kalisch, 1978). Deaconess orders existed at the time of Christ and were revived in the 1800s by Protestant churches to provide a way for women to conduct religious work (Kalisch & Kalisch). After the Crimean War, Florence Nightingale returned to England to reform Army sanitary practices and to advocate for the improved education and status for nurses. She was considered an early advocate for broadening the career options for single women (Donahue). Her outspoken nature was not appreciated by the majority of the male physicians and male hospital administrators in London who believed that women only needed to be trained as faithful maidservants because those men were not used to sharing control of the patient care arena. Male physicians and hospital administrators allowed the poor conditions in hospitals to ensue and to continue at the time of Florence Nightingale. The continuation of these conditions influenced her view that women were naturally better suited for the organization, performance, and supervision of the nursing care of the sick (Bullough, 1994a). She noted, "It has been said and written scores of times, that every woman makes a good nurse" (Nightingale, 1969/1860, p. 8). Florence Nightingale advocated for improved

education for nurses and for respectable employment of upper middle-class women who were trained as nurses. She established a formal school for nurses' training in 1860 in spite of overwhelming objections from 96 of 100 London physicians. Her school was entirely funded by the Nightingale Fund that totaled more than \$220,000.00. Donations to that fund came from the British public and from military soldiers who served in the Crimean War (Donahue; Kalisch & Kalisch). Women who enrolled in the Nightingale Training School for Nursing entered a non-religious nursing sisterhood that adhered to strict moral codes and they lived on the hospital premises like cloistered women in religious orders. Nightingale's model of nurses' training was largely concerned with the development of moral character and had military and religious origins (Kalisch & Kalisch; Mackintosh, 1997; Witz, 1992). Men were barred from the Nightingale schools of nursing and that discrimination practice persisted well into the 20th century. The limitation of men into those widely recognized schools of nursing broke the male monopolies of power in nursing and established nursing as a women's profession (Anthony, 2004; Bullough; O'Lynn, 2004, 2007a). Florence Nightingale's actions established the myth of the feminine nurse in which it is "natural" for women to be nurses and "unnatural" for men to perform the same work (Anthony, 2006).

Female Dominance of the Nursing Profession

The value of the female Nightingale nurses' education was quickly recognized and men, who were unable to obtain that formal education, became non-nursing attendants or orderlies in institutions while others worked as nurses in the military or in the area of private duty nursing. The orderlies who were employed by institutions assumed intimate care of male patients while the nurses who were female provided

intimate care to female patients. Mentally ill patients were also cared for by the orderlies at that time because of the physical strength that was needed in the absence of treatment options such as medications that included tranquilizers. The male attendants also cared for alcoholics, violent patients, and men who had genitourinary diseases (Kalisch & Kalisch, 1978; Tranbarger, 2007). The male physicians took notice of the better care that the female patients received from the female nurses who were trained in the medical model and were from a higher social class than the male orderlies. Those physicians then demanded improvements in the care of the male and the psychiatric patients (Tranbarger).

In 1872 the first school of nursing was established for women in the United States and in 1888 the first school of nursing was opened for men in this country. New York's Bellevue was the first hospital to provide a separate training course for men and psychiatric hospitals also established nursing programs for men (Anthony, 2004, 2006; Kalisch & Kalisch, 1978). Men who were admitted to these early nursing programs, that had an all male faculty, had to have good grades and pass a battery of psychological tests (Pittman, 2005). The first curricula in these all male institutions did not include obstetrics and maternal-child nursing and focused on clinical areas acceptable for male participation such as psychiatry and urology. A typical nursing program for males consisted of two years of treatment of mental illness and one year of general nursing (Anthony; Pittman). Men who were enrolled in these nursing programs were dismissed if there were any suspicions that they were homosexual. The students were observed for dating habits and were scrutinized during sports events that were part of the curriculum because it was believed that homosexual men could not excel at sports (Christman, 1988a; Pittman).

Men who were nurses do not have a history of always being welcomed into the ranks of professional nursing by female nurses. The first jobs for registered nurses who were male were in the mental hospitals. In 1919 registered nurses who were male were allowed to work in general hospitals to give treatments for venereal diseases (Brown & Stones, 1973).

The American Nurses Association, the professional organization that was formed to represent all facets of nursing, was founded in 1897 and its original constitution and bylaws did not include any provisions for men who were nurses. Men were not allowed membership into that organization until 1930 (Kalisch & Kalisch, 1978; Pittman, 2005).

A permanent United States Army Nurse Corps was formed in 1901 and The United States Navy Nurse Corps was formed in 1908. Both of these factions were originally staffed exclusively by nurses who were female even though men attended to the sick and wounded soldiers prior to that time in history (Donahue, 1996; Kalisch & Kalisch, 1978; Pittman, 2005). Influential female nurses lobbied to keep the restriction of staffing for these organizations to women and the corps barred men who enlisted or were drafted to serve in the military to work in these areas until 1955. It was reported that the 1,200 males who were nurses who volunteered or were drafted during World War II performed duties outside of the area of health care as foot soldiers. Those men could not function as corpsmen because they were too qualified to enter training for that job. Soldiers who were wounded in battle did not receive immediate on-site medical assistance because the female nurses and male physicians were not permitted to be on the front lines (Pittman).

In the closing months of World War II there were not enough female nurses to meet the anticipated needs of the military despite the large amounts of money that were spent by the government to urge female nurses to volunteer for service (Donahue, 1996; Pittman, 2005). President Roosevelt's State of the Union message (January 6, 1945) indicated a need for 20,000 female nurses to serve the military. He proposed that women nurses should be drafted to fill these vacancies because of pressing needs (Roosevelt, 1945). The American Nurses Association and the National Nursing council approved that bill but also supported the passage of a National Service Act that would draft all women. Although the nursing needs of the military were fulfilled by the filing of 10,000 applications by female nurses from January 8–29, 1945 in response to the State of the Union message, the bill regarding the drafting of nurses passed the House in early March and was sent to the Senate. The bill died after the Battle of the Bulge in May of that year after Germany surrendered and the war ended (Christman, 1988a; Donahue; Kalisch & Kalisch). The original law entitled "Army Nurse Corps, Female" that was passed in 1901 was changed after World War II to include men and men were allowed to work as registered nurses in the Army during the Korean War. Approximately 30% of the registered nurses in the military nurse corps are currently men (Kalisch & Kalisch; Pittman).

Females who were nurses in England lobbied for the Nurses Registration Act in 1919 that resulted in the publication of a registry that gave legal recognition to trained nurses (Mackintosh, 1997). The only portal to get into the registry was the receipt of formal nurses' education that had certain standards and a certain length of time that was available only to females (Witz, 1992). This act aided the public to distinguish between

educated nurses and those persons who were not formally educated. The registry was only partially accurate in the fact that only females who were nurses were allowed full membership to publish their names on that list. Trained nurses who were male did start another registry in response to the document that was exclusively female and in 1947 the sex segregation of the nurse registries ended when one official national nursing registry was established (Mackintosh).

The initiation of obstetrical education in the nurse training programs resulted in the barring of men from that type of coursework and/or clinical experiences in that area. The lack of education and nursing practice experiences in the area of obstetrics resulted in the subsequent inability of men to pass a standardized test to become registered nurses. Nursing students who were male were not allowed in delivery rooms but male taxi drivers, policemen, and firemen, who commonly did not have a high school education at that time, were allowed access to that area to learn how to assist with emergency birthing situations (Pittman, 2005). Men who were nursing students were told that if they were ever seen anywhere near the delivery room, they would be immediately dismissed from nursing programs (Christman, 1988a).

Men were not admitted to nursing schools during World War II because of the lack of draft deferment and nursing schools believed that men could be drafted at anytime and would not be able to complete the program of study. Draft deferments were not given to any men taking some type of training at that time but this practice was changed in 1951 when deferments were granted to men who were enrolled in nursing schools (Christman, 1988b).

Men commonly had difficulty obtaining advanced college degrees in nursing. Luther Christman, a noted nursing scholar, was a diploma educated nurse who applied to the University of Pennsylvania after World War II to pursue a baccalaureate degree in nursing. He was told by the female administrators of that nursing program that he would receive all “As” in all non-nursing courses and all “Fs” in all of his nursing courses because he was a man and that the university would never graduate a man with a nursing degree (Christman 1988a; Pittman, 2005).

The decades of discrimination against men in the admissions policies of nursing schools, the unequal quality of the nursing curricula, and the limited employment opportunities took a toll on the nurse population that consisted of males. In 1960 the percentage of males in the registered nurse population hit an all time low of less than 1% (Brown, & Stones, 1973; Kalisch & Kalisch, 1978). Discriminatory practices within educational institutions lessened after the initiation of civil rights legislation and affirmative action initiatives that were largely started by the feminist movement. In the 1960s increased numbers of men began to enter the profession of nursing (Bartfay, 1996; O’Lynn, 2007a). The old official barriers against men to enter the nursing profession disappeared when the change in nursing education was instituted by the four-year collegiate schools that fostered research and autonomous thinking and with the increase in the number of associate degree nursing schools (Bullough, 1994b; Hancock, 2000). The growing enrollment numbers of males in nursing education programs has continued to remain low when they are compared to the numbers of females entering the profession (Bullough, 1994b).

Women's Work

In the past groups of both men and women become nurses because of religious or altruistic convictions or because no other employer would hire them. The nursing role for both sexes was similar (O'Lynn, 2004). Today both men and women who choose the profession of nursing generally have a common goal of helping others but their roles have been differentiated by societal pressures and expectations that occurred after the middle of the 19th century (Weber, 2008). Nursing is considered a predominately female occupation in industrial nations in the world while other cultures in the Middle East and in South East Asia bar females from the profession because it is not considered a job for women (Brown & Stones, 1973).

In 2005 a group of national nursing leaders commissioned the Bernard Hodes Group to conduct an online survey to gain insight as to why the percentage of men who joined the nursing profession persistently remained small. Four-hundred-ninety nurses who were male responded to that nationwide survey. The survey respondents cited major reasons why males were not attracted to the profession. These reasons included an opinion that nursing is a traditionally female profession, the societal stereotype of being labeled as gay, poor pay, and the lack of male role models. It was noted by some of the participants in this survey that many people in the general public thought that a man who chose to spend his career as a staff nurse was a failure or lacked direction. Other respondents stated the perception that males who were nurses were viewed as men who flunked out of medical school (Bernard Hodes Group, 2005; Hart, 2005).

These survey results are very congruent with the literature associated with gender roles related to the profession of nursing. Florence Nightingale's philosophy of nursing

pivoted around what the nurse “was” rather than what she “did”. She envisioned that the images of the nurse and the woman were the same. She believed that the qualities of a good nurse were the same as the qualities of a good woman (Witz, 1992). The feminization of the profession of nursing became so pervasive that the images of nursing and caring have been used to symbolize the essence of femininity itself. It was generalized that the female members of the nursing profession have not recognized how the feminization of the nursing profession has discouraged men from choosing that career (Brown & Stones, 1973).

Sex Segregation

Occupations are not randomly distributed between men and women in society (Egeland & Brown, 1988). Sex segregation is very present in the labor force of the United States (Reskin & Hartmann, 1986). Sex acts as a major determinant of status and channels individuals into particular social and occupational roles and this practice is strongly embedded in American society (Angrist, 1969). Separation by sex is an often unequal way of distributing social power (Zimmerman & Hill, 1999). The origins of the sex-typing of jobs can be traced to the beginning of the industrial revolution and there is no indication that this practice will greatly diminish in the near future (Bradley, 1993; Kauppinen-Toropainen & Lammi, 1993). The society of the United States has been dominated by men in a patriarchal culture that has perpetuated the polarization of masculinity and femininity identities and roles. The perpetuation of this polarization has been important to the maintenance of masculinity that has been predicated on the separation of all that was male and masculine from all that was female (Evans, 2002).

Society has traditionally socialized girls to be nurturers, caregivers, peacemakers, rescuers, model mothers, and wives. Boys are taught to be strong, to master tasks, to be competitive, to be breadwinners, and to keep their feelings buried. Both of these categories of societal stereotypes are reinforced as children progress into adulthood (Flannery, 2000). Society views the women's sphere of work as characterized by an emphasis on providing services or taking care of people and the men's sphere of work as looking after the material world (Kauppinen-Toropainen & Lammi, 1993).

Masculinity has been a social construction about what it means to be male in a certain time and place. The current dominating theme that has defined masculinity in the United States has depicted the male who was white, heterosexual, and from the middle-class. Men who are gay, who are of color, or are from a poor socioeconomic class are considered to be subordinated or marginalized masculinities (Evans, 2002). Societal stereotypes that differentiate masculinity and femininity tend to degrade that which is feminine. These stereotypes are deeply entrenched in culture, social structure, and personality (Williams, C., 1992). The norms and beliefs regarding women's abilities have persistently remained unchanged in American culture (Flannery and Hayes, 2000).

The horizontal division of labor is a very visible form of job segregation in this country. Men and women are concentrated in particular kinds of work with this type of division of labor (Reskin & Hartmann, 1986). Merton (1968) noted that occupations became segregated when a large majority of the workers were of one sex and are associated with the normative societal expectation that this is the way it should be. The typing of certain occupations as male or female has consequences for entry into them and performance within them by persons who possess the "wrong sex" (Epstein, 1970, 1989).

The majority of workers in America are confined to predominantly single sex occupations and it is rare to find equal distributions of men and women engaged in the same activities in the same industries (Bielby & Baron, 1984). Work that is associated with autonomy, prestige, and authority is usually labeled as men's work and when women are in a position of authority it is typically over persons of low rank which include children, other women, or men of insubordinate status. A heightened awareness of gender distinctions sometimes provides a means of controlling workers, of undermining their resistance, and maximizing consent on the job (Epstein 1989).

The highest ranking and paying careers have been male dominated occupations that require strong backgrounds in mathematics and science. The fields of specialization which include mathematics, engineering, and the physical and biological sciences have been dominated by males. The social sciences and humanities have been dominated by females (Mickelson, 1989). There were larger proportions of men in the management and executive tiers of the female-dominated occupations. This disproportionate distribution of the work force depicts the vertical divisions of labor in which women are disadvantaged relative to men in pay and in the conditions in which they labor (Reskin & Hartmann, 1986).

The persistent societal boundaries that divide male and female may be mechanical and physical but they can be reinforced in the unnoticed habits and language of everyday life in interactions with family, friends, business associates, and colleagues. Those who have authority positions in societal hierarchies become invested in these boundaries to help preserve their own identities, sense of self, security, and dignity (Epstein, 1989).

The postwar expansion of the female labor force did not apparently alter the segregation and nature of female employment (Fottler, 1976). The occupational world has failed to reward women equitably for their accomplishments and female dominated professions have been underpaid when compared to male occupations (Williams, C., 1992). Women's work has been considered somehow inferior or of less status simply because it is women who perform these tasks. The pay for these jobs has often been lower and they have been regarded as low-skilled so that control has been "needed" from the outside (Apple, 1986; Mickelson, 1989). Hayes (2000) noted that the median annual earnings of women were 71% of those of what men earned. Women tended to be paid less than the men who were in the same occupations. The practice to pay men more than women has persisted but there have been indications that the gap in median earnings between the sexes has slightly decreased. In 2008, the median weekly earnings of women who were full-time wage and salary workers were \$638.00 or 80% of men's median earnings of \$798.00. This trend became more equal when the salaries of lower paid jobs were compared. The median weekly earnings of young women aged 16 to 24 was \$420.00 or 91% of \$461.00 which was what young men earned who were in the same age range (United States Department of Labor Women's Bureau, 2008b). The crossover of males to female occupations will remain low as long as women's jobs continue to be ill-paid (Bradley, 1993).

Women who enter male-dominated jobs get more material benefits than men who enter female-dominated jobs without compromising what society believes it is to be a woman or feminine (Kauppinen-Toropainen & Lammi, 1993; Roth & Coleman, 2008). Men have less to gain and much to lose by choosing a non-traditional career (Simpson,

2005). Men who work in traditional women's occupations receive lower economic benefits, hold lower social prestige than men who work in traditional men's jobs, and need to cope with derogation of their masculine identities (Bradley, 1993). It was hypothesized that when women invaded an occupation to the point of becoming a large minority within it, the occupation became increasingly unrespectable for a man to enter it (Segal, 1962).

Men have been less likely to enter female sex-type occupations than women have been to enter male-dominated jobs. This trend has been due, in part, to the social and cultural sanctions applied to men who perform women's work (Kauppinen-Toropainen, & Lammi, 1993; Williams, C., 1992). Men's identities seem more at risk when they take nontraditional roles (Epstein, 1989). Men who have performed women's work have not measured up to the societal ideal of masculinity (Evans, 2002). A man who has moved into a woman's occupation has been perceived by the outside world as taking a "step down" in status (Williams). A man's prestige and self-esteem may suffer when he is in an occupation that is mostly staffed by women (Segal, 1962). It was noted by Bradley (1993) that in times of increased job loss unemployed men do not displace employed women in the labor market. It was reported by Epstein that some men would rather suffer unemployment than accept relatively higher paying women's jobs because of the damage that this would cause to their identities.

Society's Influences on the Profession of Nursing

The feminization of nursing made the profession less attractive to males relative to other occupations (Fottler, 1976). Early in the 20th century health care adopted a family model of labor division (Evans, 2002). The physicians who established this hierarchical

system were male and white (Zimmerman & Hill, 1999). The predominately male occupations that consisted of physicians and pharmacists became high status and high-pay occupations and nursing, which was predominately female and associated with domestic labor, suffered traditional low societal status and pay (Evans). The hierarchy of healthcare occupations reflected the gender and racial stratification systems that were present in mainstream society. The influence of the dominance of the physicians over the female workers in the healthcare system has severely limited the females' autonomy or prestige to be considered professionals (Zimmerman & Hill).

Bradley (1993) noted that women have sometimes been preferred for certain jobs, not only because of the cheapness of their labor but because they were considered to be docile, submissive, less likely to resist efforts, and to complain about poor conditions and the lack of rewards. The Victorian nurse educators in America mirrored the stereotype of the place of women in society at that time. This stereotype was that the role of women was to serve men's needs and conveniences. Nursing curricula were created in fashions that were reflective of society's women's roles that appealed to females (O'Lynn, 2004). The image of the oppressed professional nurses was formed into that of dependent, passive women who were less creative than men. There was a common belief that nurses were capable of serving humanity with compassion under male guidance while avoiding open disagreement with physicians at all costs (Anthony, 2004; Marks, 1980; Zimmerman & Hill, 1999). Florence Nightingale's conception of the nurse as a devoted, disciplined, and selfless worker combined with the strategy of on-the-job training provided hospitals with cheap, disciplined, and compliant labor (Witz, 1992).

The Role of the Media

The mass media has also played a role in perpetuating the general public's image of nursing as a feminine profession. The feminine images that have depicted the profession of nursing have changed throughout history. Prior to the mid- to late-nineteenth century, a large proportion of American and British nurses were typically untrained, of lower or servant class, often alcoholic women. In 1843 the writer Charles Dickens included the nursing characters of Sissy Gump and Betsy Prig in his novel *Martin Chuzzlewit* to symbolize the standard of nursing that was available at that time (Kalisch & Kalisch, 1982; Witz, 1992).

Traditional cultural symbols that have been communicated by the mass media that are commonly associated with the profession of nursing from the time of Florence Nightingale to the present generally fall into the categories of handmaiden, angel, battleaxe, and whore (Jinks & Bradley, 2004). The association of the image of handmaiden was associated with the societal role of women in the Victorian era. The angel image has been associated with an image of Florence Nightingale as she carried her lamp to serve wounded soldiers in the Crimean War with compassion in fulfillment of Christian duties.

Some novels written in the 1920s did not portray nursing in a positive image but during World War II, American nurses generally received unreserved backing and favorable regard. Nurses were portrayed either as aging authoritarian spinsters or as women who frequently engaged in casual sexual encounters with males after 1960. Examples of these characters for this period of time were Nurse Ratched in the 1962 novel and 1975 film *One Flew Over the Cuckoo's Nest*, Hot Lips Houlihan in the

television series *M.A.S.H.*, and various nurse characters who were featured in soap operas. Nurses and other “Women in White” were featured in the October 1983 *Playboy* magazine. These images were detrimental to the profession because they perpetuated the societal stereotype of nurses as sex objects (Donahue, 1996).

Men are not frequently portrayed as professional registered nurses by the media. A cover story in the January/February 2009 issue of *NurseWeek* applauded the long-running fifteen year television series *ER* for crafting the strongest nurse characters in prime time television. However, the picture of the nurse on the journal cover and all of the nurse characters in this television series that were mentioned in the article were female (Spader, 2009). A character who portrayed a nurse who was male, Paul Flowers, was seen in four episodes of the television series *Scrubs* during the series’ second season in 2003. This nurse character was depicted as having a very masculine disposition despite the last name of “Flowers”. A female physician fell for him romantically and she became the laughingstock of the hospital for seeing a “murse” (a nurse who is male) who did women’s work (Lawrence, 2003; Tahmincioglu, 2003). One of the central characters of the movies *Meet the Parents* (2000) and *Meet the Fockers* (2004) (Roach, 2000, 2004) was a nurse who was male that interestingly had the name of Gaylord Focker. Gaylord is pictured as a registered nurse in the beginning scenes of both movies doing invasive procedures that involved the genitalia of his patients. The first movie’s opening scene implied that he removed a urinary catheter from a male patient who mistook him for a doctor and the second movie’s opening scene implied that he completed a pelvic exam on a pregnant woman. He later delivered the baby to an immigrant couple who, with looks of horror and disbelief on their faces, had difficulty comprehending that a man would be

a nurse. Negative societal stereotypes of males who were nurses and parents that would raise a son who would become a registered nurse were polarized to Gaylord's future father-in-law's character that emulated traditional societal male dominant stereotypes. Gaylord's depiction of a male nurse, as well as his parents' characterizations, did not measure up to his future father-in-law's standards of masculinity. The father-in-law's standards mirrored common societal stereotypes that have based on sex. The Fockers were portrayed as liberal, emotional, weaker, disorganized, not competitive, not goal oriented, "touchy feely", and inept. The following words of the opening song named *A Fool in Love* for the first movie *Meet the Parents* illustrated these suppositions:

Look at the light coming over me. Show me a man who is gentle and kind and I'll show you a loser. Now, show me a man who takes what he wants; ohhhhhhhhhh how exciting, ohhhhhhhhhh how exciting so the poet sings. When you're a fool in love... (Newman, 2000).

The female image continues to prevail in the marketing of merchandise for nurses and the *Nurses Station* is a widespread national magazine that sells these items. The vast majority of the merchandise from this catalogue consists of nurse angel pins, demure female figurines who are attired in white uniform dresses and nursing caps, purple or pink work and casual clothing, purses, books written by nurses who are female, and other various items that include mugs with logos printed on them that have a female connotation (Nurses Station, 2009).

Role Strain

Role strain is labeled as discomfort with gender role behavior that may arise if tensions exist between one's gender identity and occupational stereotyping. Men who work in occupations dominated by women, such as nursing, have two social statuses as they experience minority status in the workplace even though they belong to the

dominant society in which they live (Pittman, 2005). Men in non-traditional occupations experience conflicts between the need to maintain masculine identities and the female associations or demands of the job. Men who work in female-dominated occupations may experience conflicts between their masculine identities and work identities, reactions of their friends, family, and peers to their non-traditional career choices as well as their own responses to these situations (Simpson, 2005). A research study conducted by Whittock and Leonard (2003) related that the perception among males in the general population was that nursing was still regarded as just a caring job with much time spent “wiping bums” and “cleaning shit”.

Role strain has the potential to influence aspirations, leadership goals or career exit decisions (Simpson, 2005). Kauppinen-Toropainen and Lammi (1993) stated that men in female occupations deal with role strain by assuming work roles that supported their masculine identity. Males who were nurses were noted to work in areas that involved areas of specialization, separate from general nursing that is perceived to be largely female, that involved the use of technical machinery such as the emergency room or intensive care units (Kauppinen-Toropainen, & Lammi; Simpson, 2004). These units have been described as “adrenaline charged” because of the demand of quick thinking under pressure that is required when working in these specialty areas (Simpson, 2004).

Egeland and Brown (1989) conducted research on males who were nurses in Oregon and concluded that participants in their study preferred fields of nursing that were congruent with the male role both as students and as practicing registered nurses. They reported that respondents from that sample perceived the following seven fields as most congruent with the stereotypical male role were administration, the emergency room,

anesthesia, intensive care/coronary care units, the operating room, psychiatry, and industrial nursing in that order. Preferences for working in congruent fields were stable from the time that the respondents were nursing students to the establishment of a career. The researchers suggested that these men had stability in their perceptions of the congruence of various nursing fields with the male sex role and intentionally sought out these fields after experiencing role strain in less congruent fields within the profession. Males who were nurses in that study not only preferred more congruent fields but over time became increasingly employed in them. That finding was evidenced by the comparison of the participants' areas of employment for their first jobs to their most recent jobs. This data showed that there was a sharp decrease in the percentages of men who remained employed in the areas of general medical and surgical nursing and there was a sharp increase in the fields of anesthesia and administration.

This research also addressed the effects of societal stereotypes on the profession of nursing and their effects on the longevity of males who were nurses' employment status. They found that some of the males who were nurses were not bothered much by these public images while others learned to cope with them. They noted that the males who were nurses that accepted stereotypical views were likely to experience notable role strain whether or not they were employed in a congruent male nursing field and were prone to leave the field of nursing permanently. The researchers noted that approximately 10% of the respondents in their study indicated that they did not expect to be working as nurses within five years of the time of the survey. This finding was significant because these respondents were employed as nurses and would not be eligible for retirement at the time that they would leave the profession (Egeland & Brown, 1989).

Laroche & Livneh (1983) stated that the acceptance of males who were nurses by the general public was influenced more positively by people who had increased amounts of formal education and found that women were more accepting of males who were nurses than males. A research study conducted by Chur-Hansen (2002) indicated that there were some attitudinal changes between the years of 1984 to 2000 in the tendency to reject stereotypes of nursing as a female profession. These changes in attitude have been encouraging but the cycle of bias regarding traditional stereotypes has continued to limit men entering the field of nursing (Meadus & Twomey, 2007). Men who enter the women's occupation of nursing within the male dominated social system are very likely to be guaranteed a second-class status in society (Bullough, 1994b).

Men Who Choose to Enter the Profession of Nursing

The Influence of Others

Research studies have revealed that the majority of men who enter nursing were more likely to be influenced by friends and relatives who were nurses to enter the nursing profession. Okrainec (1990) reported that 47% of men versus 33% of women were influenced in their decision to become a nurse by friends and relatives who were nurses. Parents, especially mothers who were employed in nursing or other healthcare professions, had the greatest influence on men to become nurses (Brady & Sherrod, 2003; Whittock & Leonard, 2003). Male participants in a study conducted by Kelly et al. (1996) reported that family members, especially spouses, provided encouragement for them to enter nursing and gave them the most moral support during the educational process. Some males who were nurses stated that they were motivated to enter the profession after

experiencing some form of a caring situation that usually involved a family member (Whittock & Leonard).

Williams, R. (1973) conducted a study of male nursing students who were enrolled in baccalaureate nursing programs. Data from that research revealed that seventy-three percent of these students first considered becoming a nurse after high school compared to approximately ten percent of the sample who first considered that career option before the age of eighteen. One half of these participants indicated that they entered an institution of higher education to obtain training in another field. Friends, both male and female, were noted to be the most influential persons to enter the profession for the men in the study. The participants noted that parents were supportive of their career decisions but brothers, other relatives, and acquaintances showed mixed feelings more frequently. Many of the men reported that they had health care experience as nursing assistants or as corpsmen in the military and that experience initiated their first interest in a career in nursing. Eighty-one percent of the respondents stated that the most important reason for them to enter nursing was the opportunity to help people. Ninety percent of the participants indicated that they would probably or definitely choose nursing as a career again if given a choice and sixty-six percent of the nurses would encourage a younger brother or sister to enter the nursing profession. Those respondents tended to be from middle-class families, were older, and married when they entered nursing school.

Brown and Stones (1973) reported that nursing students who were male reported that they chose to become nurses because of close family contact or after serving on medical units in the military. Experiences in a hospital setting were also important to these research subjects and impersonal sources of contact such as plays, films, or novels

that portrayed nursing were not important in their choice of profession. They reported that nursing was not a frequent choice for the men at the time of high school education. Less than one in eight of these participants considered nursing as a choice of career before the age of fifteen and this is a contrast to one-half of females who expressed interest in the occupation before the age of twelve.

Reasons Men Choose Nursing

Brown and Stones (1973) also compared intrinsic and extrinsic elements of satisfaction with the choice of nursing education with the subjects. The intrinsic satisfaction elements of interesting work, ability to make decisions, tasks matched abilities, responsibilities, and pride in work were ranked higher than the extrinsic satisfaction elements of pay, security, good workmates, working hours, and conditions that were cited by the research subjects.

In an earlier study, men stated that they became nurses because they viewed employment in that profession as secure and that the job that was a cut above manual, semi-skilled work that they would have performed otherwise. These men were more interested in obtaining security early in their careers through limited upward mobility rather than achieving some more striking success later (Segal, 1962). Mulherin (2007) reported that men stated that they chose a nursing career because of the wide career paths, opportunities for advancement, future job security, and making a difference.

Respondents who completed the Men in Nursing Survey (Bernard Hodes Group, 2005) cited the following reasons for entering the nursing profession: the desire to help people, to work in a profession that had multiple career paths, to have a stable career, and to be able to work in a variety of geographic locations. The survey also revealed that

forty-four percent of the respondents chose nursing as a second career, twenty percent immediately went to a nursing school after high school graduation, and seventeen percent enrolled in nursing education programs after serving in the military. Forty-five percent of the respondents were planning to obtain an advanced degree (Bernard Hodes Group; Hart, 2005).

Williams, L., and Villemez (1993) categorized men who work in women's professions as seekers, finders, or leavers. The categories of seekers and finders were classified as entry dynamics that influenced men to go into a female-dominated profession. Seekers were identified as men who preferred to work in female-dominated occupations and actively sought jobs that were female-dominated. Finders were categorized as men who passively come across female-dominated occupations while seeking jobs that are commonly recognized as masculine by society-at-large. Most men who work in female-dominated occupations are classified as finders who entered that field of employment almost by default in that they were not actively seeking that type of job but "fell into it" either through availability or convenience. Leavers were men who worked in women's occupations and left them. Simpson (2005) interviewed men who were employed in female-dominated occupations and discovered another category of entry dynamics of men who work in non-traditional jobs and labeled this category as settlers. These men tried a variety of different, often masculine, jobs with limited levels of job satisfaction before settling in their current female-dominated occupation. Data from that study revealed that the seekers and the settlers stated that their current non-traditional occupations were high on their preference scale and were their best choices at the time that their career decision was made. Settlers generally believed that they had

found the right occupation after experiencing periods of dissatisfaction in their previous job-related roles. Finders related that their female-dominated jobs were second best and involved some compromise around an alternative and preferred option. The majority of men who fell into the classification of settlers claimed a preference for remaining close to professional and occupational practice rather than moving into management positions. This group of men placed a high priority on self-fulfillment and job satisfaction.

Reactions of Others

All of the men who were interviewed stated that male friends and acquaintances were less accepting than their female peers of their non-traditional career choice. The term of stigma was commonly used by the participants to describe the reactions of others towards their career role. Most of the respondents claimed that they “were not bothered” or had “grown used to” such negative stereotyping at that stage of their lives. Those participants stated that they most likely would have not had that reaction at an earlier age of their lives (Simpson, 2005). The men used various strategies to minimize the potential for being negatively stereotyped such as the re-labeling of the non-traditional role to minimize feminine association with it and by placing emphasis of the masculine components of the job to distance themselves from the female components of the job (Simpson, 2004, 2005).

The Nature of Nursing Curricula

The Feminine Agenda

Men who enter formal nursing education programs may lack an initial awareness of a hidden curriculum that is embedded in nursing programs of study (Hayes, 2000). Since the time of Florence Nightingale, nursing norms have generally been created by

White women and taught to White women (O'Lynn, 2009). The professional socialization process that the nursing profession applies to help novice practitioners become successful professional practitioners is geared toward women (du Toit, 1995).

Reports from recent research studies reveal that the barriers that men face as nursing students are pervasive, consistent, and have changed very little over time (O'Lynn, 2004). Feminine attributes have shaped the character of present day nursing education. Nursing curricula have been developed from national professional standards and codes that had a very strong female bias when they were initially formulated. The majority of nursing instructors, textbook authors, and test item writers are females who use language that is traditionally geared toward women. The culture of nursing is embedded in feminine intuitive processes, personal reflection, psychosocial content, and emotion (Dyck, Oliffe, Phinney, & Garrett, 2009; Tisdell, 2000). Faculty members commonly use feminine pronouns in discussions that concern nurses. Nurses are often depicted as or referred to as caring females in educational materials and presentations and men are usually pictured or referred to as the recipients in need of nursing care. These types of curricula closely mirror feminist pedagogies that include authors and course content that are written by women. Feminist educators try to conduct learning activities that encourage connection and relationship and that take affective as well as rational and cognitive modes of learning into account (Tisdell).

The feminine culture of nursing education can be seen when instructors use a female perspective to present course materials. An example of the use of this perspective included a familiarity with the female anatomy and embodied experiences that were noted by Dyck et al. (2009). These researchers observed a nursing instructor who was

teaching urinary catheterization address the female genitourinary and perineal anatomy very briefly because everyone in the class “knew this” and spent a greater amount of time to detail male genitourinary anatomy and the catheterization technique for that sex. Men were frequently called upon in class to give a men’s perspective or male input and an instructor was noted to frequently asked to “hear from the guys” to elicit homogenous opinions that would represent all males in society. Those actions by that educator made the male students feel singled out from the females and not truly integrated into the class.

The majority of nursing educators do not consciously discriminate against men but they may inadvertently exhibit behaviors that perpetuate gender bias (Anthony, 2006). Men are generally not acknowledged as a part in the formation of the history of the nursing profession as books that address the history of nursing traditionally recognize Florence Nightingale as the founder of the nursing profession (O’Lynn, 2007a). It has been reported that anti-male remarks have sometimes been made by female nursing instructors during class presentations (Brady & Sherrod, 2003; Sherrod, Sherrod, & Rasch, 2005; Weber, 2008). A factor that compounds the gender bias issue in nursing education is that there are very few males employed as faculty members who can serve as role models to nursing students of both sexes (Brady & Sherrod; Sherrod et al.).

It was reported that female nursing educators were generally unaware of the inherent gender bias that is communicated to students enrolled in their programs (Bell-Scriber, 2008). Textbooks, instructional methods, and teachers’ lectures are not only sources of subject matter but are also influential sources for students of learning about gender (Hayes, 2000). Nursing textbooks and the organization of curricula typically reinforce the typical societal roles and images of men and women and encourage “good

girl” behavior such as the need to obey authority. Nursing instructors have been noted to try to suppress and mold male students into feminine-model nurses by failing to acknowledge that there can be a variety of approaches in the delivery of patient care (Brady & Sherrod, 2003; Hayes; O’Lynn, 2007b).

Effects of Gender Bias in Educational Settings

These descriptions of gender bias in nursing curricula are likened to a reversal of the chilly classroom phenomenon that was described in a study by Hall and Sandler (1982). This study was initiated because there was concern of low enrollment numbers of women in traditional masculine fields as greater numbers of women entered the higher education system at that time. These authors reported that the majority of the predominantly male faculty members stated that they wanted to treat all students fairly but the research findings indicated that there were some teachers who overtly or more frequently inadvertently treated men and women differently in learning situations. The researchers concluded that the different treatment of students based on sex could be damaging not only to the female and male students but to the educational process itself.

Teachers’ behaviors such as singling out or ignoring female students during learning activities because of their sex, making more frequent eye contact with male students than female students, assuming postures of attentiveness only when male students spoke, and making direct sexual overtures to women in class were found to have a negative impact on the female students’ intellectual growth and career development. These negative impacts that affected female students included discouraging classroom participation, preventing them from seeking help outside of class, causing them to drop or avoid certain classes, causing them to switch majors or leave some institutions,

decreasing collegial relationships with faculty, dampening career aspirations, and undermining confidence while promoting feelings of helplessness (Hall & Sandler, 1982).

The negative effect on male students who were present in those teaching situations was that there was reinforcement of their own personal negative views about women because those views were confirmed by persons of knowledge and status. Teachers' sexist remarks that may have reinforced these males' views included: citing examples that reflected societal ideas of men's and women's social and professional roles such as the male doctor and the female secretary, the disparagement of women in general, defining women in terms of their sex rather than their professional status, the devaluing of women's seriousness and academic commitment, and making comments that referred to males as men but to females as "girls" or "gals" rather than women. These sexist reinforcements were thought to hamper these men to regard women as equals in future professional and personal relationships (Hall & Sandler, 1982).

The authors stated that the subtle and/or inadvertent incidents could do the most damage to all of the students because they often occurred without the full awareness of the teacher or the students. The researchers also identified another form of devaluation of women in these academic settings when female students displayed behavior or made comments that were considered to be "masculine" rather than "feminine". The female students reported that they were frequently treated as an oddity for displaying that type of behavior or making these types of comments while the male students were frequently praised for possessing the same identical attributes. Some women who did well in academic areas were sometimes praised for "thinking like a man". The researchers

advocated for the need of a college climate that acknowledged female students as individuals that would give recognition to their abilities, contributions and accomplishments that could help them grow and succeed (Hall & Sandler, 1982).

Anthony (2006) noted that subtle incidents in gender bias may significantly affect students' learning and success in nursing curricula. That researcher advocated that nursing faculty members set the climate for learning and should be active role models in accepting and welcoming men into the profession.

Differences in Communication and the Processing of Knowledge Between Males and Females

Brady and Sherrod (2003) stated that male nursing students need to learn to "think like nurses" and also have to learn how to "think like women" to successfully complete a program of study in nursing. The actual implementation of this idealized statement can be very difficult and can create conflict for male nursing students in female-dominated curricula because men and women have different approaches to communication and learning. Men and women have been found to convey different interests and concerns when they were in similar situations so knowledge about certain similar learning situations may be different. These differences are the product of society's stereotypical system of gender relations that have lead men and women to develop different ways of creating and sharing knowledge (Hayes and Flannery, 2000).

Gray (1992) studied differences in communication and the processing of knowledge between the sexes and made generalizations about these differences. The following paragraphs of this literature report broad generalizations that are based on that author's perspectives regarding learned male and female roles that reflect society-at-

large. The author reported these generalizations as characteristics associated solely on the basis of biological sex.

Gray (1992) speculated that men experience fulfillment primarily through success and accomplishment and that they value power, competency, efficiency, fairness, security, and achievement. The sense of self is defined through the ability to achieve results and to attain goals by self. Men value autonomy. They generally try to work out problems themselves and rarely talk about those problems to others unless they deem that expert advice is needed from people who they respect and trust. Men tend to believe that women are seeking “a fix” or a solution when discussing concerns with them or when soliciting advice. Men generally do not offer advice or help to other men unless they are specifically approached and asked to give an opinion. Men do not talk just for the sake of sharing as they generally value communication that is brief, direct, and correctly worded.

It was also reported that women generally value love, communication, beauty, and relationships. Women generally spend a lot of time supporting, helping, and nurturing one another and define a sense of self through their feelings and the quality of their relationships. A sense of community is important to women and talking, sharing, and relating to each other is a source of fulfillment. Women prefer solving problems in groups. Women’s relationships were found to be more important than work and technology. Women do not tend to prioritize problems. They obtain relief by randomly expressing their personal feelings and believing that they have been understood. Some women got emotionally involved in the problems of others to forget their own painful feelings (Gray, 1992).

Implications for Educational and Work Situations

The comparison of these communication patterns and approaches between the sexes to life experiences yielded significant generalized differences that can produce frustration and conflict in learning, work, and personal situations. Men are generally goal oriented and women are generally relationship oriented (Gray, 1992). Men tend to give praise less frequently and women give and expect to receive praise on a regular basis (Yoshimura & Hayden, 2007). Men tend to have difficulty with relationships and females have problems with individuation. These differences can be influenced by men's moral sensibilities that reflect a concern for justice and women's moral sensibilities that reflect a concern of care (Gilligan, 1982).

Males tend to focus on one problem at a time and withdraw from others to solve that problem. If men can't find a solution to a problem they disengage their minds from those predicaments and do something, preferably an outdoor activity, to forget those dilemmas. Women who feel overwhelmed by stress will talk not only of the present circumstances but will also address past problems, future problems, potential problems, and problems that have no solutions. Men believe that when women approach them to discuss problems the women are extending an invitation for them to fix those problems when in fact, women talk to relieve stress by discussing problems and are not necessarily soliciting the "quick fix" solutions that men want to offer them. Men become frustrated when women talk about problems that they [the men] cannot solve. Men generally are more likely to rush to make judgments and to reach decisions more quickly than women. This tendency frequently leads to perceptions that the feelings of others are ignored or invalidated. Women tend to be more nonjudgmental than men. Men tend to leave items

alone if they are functioning and women possess the view that if something is working, it can always be evaluated for further improvements. Men experience a perception of weakness and decreased trust from others when receiving unsolicited assistance and advice from women whereas women tend to see these acts as an expression of caring and growth (Gray, 1992).

Reported Areas of Interest in Nursing Education and Career Choices

Okraineec (1990) conducted a research study on male and female nursing students enrolled in nursing education and found that about two-thirds of each group found nursing education more challenging than expected. The men in the study indicated that anatomy and physiology, surgical nursing, and disease pathology were the top three subjects of greatest interest in comparison to the ranking of anatomy and physiology, obstetrics, and disease pathology as the top three subjects of greatest interest to the female participants. The men and the women in the study differed most in their career plans. The men were attracted to administrative careers and the acute care specialties of emergency nursing, adult intensive care, operating rooms, and nursing education. The women who were surveyed wanted to work in obstetrics, operating rooms, newborn nurseries, and pediatrics. Muldoon and Reilly (2003) reported that both male and female nursing students viewed the areas of midwifery and school nursing as areas that were appropriate only for females who were nurses. This finding was supported by research conducted by Williams, C., and Heikes (1993) who reported that males who were nurses identified obstetric nursing as more compatible with the interests and capabilities of females who were nurses.

Challenges of Males Enrolled in Nursing Education Programs

The growing body of qualitative research into male lived experiences in nursing programs supports the fact that the male experience in nursing school is perceived to be different than experienced by female nursing students (Anthony, 2004). One major adjustment to nursing education situations that has been cited by some male nursing students was a change in the way that they interacted with women (Streubert, 1994).

A Different Approach to Learning

Male students are often surprised with the rigor of the academic and clinical load in nursing and find that studying is necessary to pass nursing courses (Anthony, 2006; Kelly et al., 1996). Some male students who were surveyed stated that the assignments were overwhelming and considered dropping out of school. Many of the men became frustrated with class content that appeared to irrelevant. The female approach to learning was described as experiencing a curriculum in a foreign language (Kelly et al.). Male nursing students have reported difficulty in choosing answers on tests because the tests tend to be written in gender-biased language (Mulherin, 2007). Test items that require an emotional, intuitive, and personalized response are frequently present in nursing tests. This type of testing item has been found to favor the learning styles of female students (Brady & Sherrod, 2003).

Males and females can clash at times simply because their brains process information and approach problem-solving differently in educational and work situations. These patterns that were established in childhood persist into adult learning situations. Men usually enter nursing programs with an action orientation of “doing” and are surprised with the initial focus of the feminine-based curricula that have a preference for

subjective and affective ways of learning that emphasize therapeutic communication, listening, and reflecting (Anthony, 2006; Hayes, 2001).

The dominance of feminine relationships and patterns of communication in nursing curricula can make men feel “left out in the cold” (Brady & Sherrod, 2003; Sherrod et al., 2005; Weber, 2008). Men have perceived an overemphasis on emotion in the nursing curricula and the expectations for a high degree of personal reflection, emotional expression, and introspection (Dyck et al., 2009). The “old girl’s club” has been so entrenched in nursing curricula and in nursing practice areas that very few of the club’s members acknowledge its existence (O’Lynn, 2007b; Weber).

Male students do not fit in the mold of “traditional” female nursing students and their behaviors in the classroom and in areas of nursing practice may be considered “nontraditional” because of the utilization of male learning styles and communication patterns. These “nontraditional” mechanisms of learning and communication are often not valued or acknowledged by the predominantly middle-aged female faculty (O’Lynn, 2007b). Faculty members who teach in nursing programs are typically white females who are in the age range of late 40s to the early 50s. These faculty members are not likely to intuitively identify with the experiences of these younger men because they were most likely socialized to value the feminine attributes of nursing (Anthony, 2006). Nursing students who are male are frequently stereotyped as a homogeneous group of men and are not treated as individuals by faculty members (Dyck et al., 2009).

“Nontraditional” behaviors displayed by male nursing students in learning situations include the tendency to display independent problem solving and self-direction in learning. These behaviors include a preference to learn from textbooks, manuals, and

policies rather than from others in group work situations (Brady & Sherrod, 2003). Male students were more likely to challenge nursing instructors to present a counterpoint role in the classroom as opposed to female classmates who were more often reluctant to disagree with nursing instructors. Males were observed as displaying humor more frequently and often took on the role of the “class joker”. They often adopted extroverted leadership and assertive spokesperson roles. They were noted to be advocates for their female classmates (Dyck et al., 2009).

Male students have expressed frustration when female students took valuable time to discuss relationships, feelings, and personal experiences instead of making decisions, accomplishing tasks, and meeting learning needs. This process was described as “overfeeling” and “underdoing” (Brady & Sherrod, 2003; Dyck et al., 2009). Male students have been noted to become introverted during problem solving situations and this focusing behavior made them appear to be quiet and withdrawn while they were contemplating possible solutions to circumstances (Brady & Sherrod).

The value of competence has been noted to be important to male students and unsolicited advice and supervision by female nursing instructors has not usually been welcomed. These behaviors could be interpreted by male nursing students as not knowing what to do or that they cannot do the task without help. It was noted that male students were unlikely to seek help from nursing instructors even if they were struggling in class or in the area of nursing practice (Brady & Sherrod, 2003).

Dyck et al. (2009) reported that sexual tensions were present between the men who were enrolled in nursing education programs and between male and female classmates. One respondent stated that single men had access to a “gold mine” of single

females to date. The resiliency of the stereotyping of unmarried nursing students who were male as gay was also acknowledged by nursing instructors.

Additional challenges that male students have experienced in nursing education included the tendency to experience social isolation from other men. This factor is prevalent because of the lack of male teachers and male peers in nursing education classes that traditionally have a disproportionate enrollment of a large percentage of women (Sherrod et al., 2005). Male nursing students have also stated that they were reluctant to participate in classroom activities because this behavior would make them much more visible as minority members of the class and that they would be more open to increased scrutiny by female classmates (Anthony, 2006; Bell-Scriber, 2008). Some students who were male have stated that they were not included in conversations with other female students unless they made the first move (Kelly et al., 1996).

Student Challenges in Nursing Practice Situations

All nursing students are required to complete practice experiences to provide direct patient care in all areas of nursing that involve the profession of nursing and patients often refuse to have nursing students who are male care for them because they are men. Smith (2006) reported that most males who were nursing students were not offended by client refusals but believed that the situations were unfair because they felt competent to do the work. Nursing students who are male face challenges from patients, patients' families, and female registered nurses when completing personal cares during nursing practice experiences especially in the areas of labor and delivery and postpartum (Brady & Sherrod 2003; Weber, 2008). Men who are "just nurses" can be barred from seeing or touching a woman's fully naked body and these restrictions are lifted when that

same male becomes a medical doctor (Farrell, 2005). Patients do not usually question physical examinations by nurses who are female, male doctors, and medical students of either sex (Brady & Sherrod; Weber).

Male nursing students that were interviewed by Patterson and Morin (2002) stated that the anticipation of the maternal-child rotation was stressful. Many of these research participants related that some of their perceptions were enhanced by former students who were male and had completed that rotation. The research participants expressed a desire to learn, meet course requirements, and provide good nursing care but verbalized a strong fear of rejection from the patients because they were men. These men had a strong belief that maternal-child nursing was a setting for women and that men who were not husbands or physicians were just visitors or “invaders”. Those nursing students avoided the postpartum unit by volunteering to rotate to the nursery or to labor and delivery many times because it was reported that they felt more comfortable in these settings. The male students in that study felt competent to perform postpartum assessments when supervised by faculty. The male students also reported that they experienced feelings of being alone as well as being an outsider when they realized that they were the only men providing care on the postpartum units. The students who were male expressed relief at the end of the rotation and stated that they had a great experience but would not seek employment in that setting.

Males Who Are Nurses in the Workplace Setting

Distribution of Male Nurses

Populations of males who are nurses are not evenly distributed in hospital work structures. Islands of masculinity are established within female professions to minimize

role strain between gender identity and the occupational role of the male workers (Kadushin, 1976; Segal, 1962). General bedside nursing may be considered “women’s work” and men tend to gravitate to more fast-paced technology-driven areas such as critical care, emergency departments, and operating rooms (Mulherin, 2007; Weber, 2008; Williams, C., & Heikes, 1993). A benefit for males who are nurses that work in an area that employs other men is that nurses who are male can establish relationships with other men. These men can also blend in with other male co-workers and have less of a chance of being scrutinized as readily as a member of a minority work population (Mulherin, 2007).

The Effects of Societal Stereotyping in the Workplace

Segal (1962) reported that nurses who were male did consider themselves professional men but were aware that their type of work did not place them in the same category of prestige that men enjoyed who were in traditional male higher ranking professions. Societal stereotypes of men who are nurses include that of being effeminate, homosexual, wimpy, desperate, failures, failed medical school applicants, sexual deviants, misfits, or womanizers (Burton & Misener, 2007; Segal; Williams, C., 1992). Patients frequently express surprise to encounter men who are providing nursing care. Many patients believe that these nurses are doctors but rarely assume that they are nurses’ aides or orderlies. Males who are nurses are frequently asked by patients and their families why they chose to become nurses and did not go to medical school (Floge & Merrill, 1986; Segal; Weber, 2008). Patients tend to ask men who are nurses about their marital status in attempt to ascertain if they are gay (Floge & Merrill). In a research study conducted by Williams, C., and Heikes (1993) some of the nurses who were male felt

compelled to confirm their heterosexuality with the researchers during the interview process. The research participants alluded to sexuality and sexual orientation during their interviews even though there were no questions that explicitly asked about sexual orientation. One of the respondents described floor nurses who were male as homosexual or feminine, one participant blamed the low status of nursing on the “few fairy guys”, and one made it very clear during the interview that he had a wife.

Communication in a Female-Dominated Workplace

The projection of negative attitudes, prejudice, and discrimination of nurses who are male by some female coworkers has been reported to exist in the workplace (Fottler, 1976). Nurses who were male frequently reported the lack of development of friendships at work, feelings of isolation, and fears that female coworkers wouldn't be around when help would be needed (Farrell, 2005). Floge and Merrill (1986) stated that mistakes made by nurses who were male were noticed more often and were repeatedly commented on by female coworkers. Men who are nurses are frequently a source of gossip for female coworkers. Both sexes gossip but Pringle (1989) stated the generalization that men gossip about “important” things and women gossip to be “nosey”. Gossip frequently evolves to “bitching” that occurs in all-women workplaces. The “safe” audiences found in company of female coworkers are expected to hear and sympathize with the discussions of each others' trials and tribulations with no expectations of changing any of the situations that are discussed. This phenomenon occurs in response to women's feelings of low self-esteem, feelings of marginalization, and feelings of inferiority to make the females feel better. It was noted that the presence of men in the workplace did break up the female communication pattern of bitching through the establishment of work boundaries.

The presence of males who are nurses in the workplace may be viewed as an interruption in the camaraderie of an “all-girl’s network” and conversations at work may remain directed toward other females because of fears of patriarchal control and sexual harassment by male coworkers (Yoshimura & Hayden, 2007). The female “old-girl network” has the two purposes of leaving out males and to leave males feeling left out (Farrell, 2005).

Women tend to talk about more intimate topics at work and men tend to put on more of a facade and maintain their boundaries surrounding their personal lives (Pringle, 1989). Topics of conversation initiated by female nurses in the workplace that exclude male coworkers frequently include details about dates, dirty jokes, comments about their husbands’ sexual habits and sexual needs, boyfriends’ and husbands’ choice of clothing and haircuts, various details about the female menstrual cycle, and sharing experiences about giving birth, breastfeeding, and raising children. Men who were present at these conversations stated that they made no attempts to try to include themselves in some of those “girl talk” sessions (Floge & Merrill, 1986). Men do not generally interrupt these sessions but generally wonder when the females are going to get to the point of the conversations. The nurses who are female may be concerned why the nurses who are male appear to be withdrawn or unfriendly (Yoshimura, & Hayden, 2007).

Males who were nurses were observed by Floge and Merrill (1986) to share some topics of conversation about their outside lives at the workplace that included mortgages, vacations, divorce experiences, daily activities, family members, and the food they ate. Some nurses who were men are very reluctant to join conversations about conditions in the workplace because of the attention that it would draw to them and they didn’t want to

be labeled as “trouble makers”. The lack of involvement of nurses who are male in all conversations can mean that they can lose out on gaining pertinent information that may be disseminated in the discussion.

Nurses who are male are not usually included in social events that involved female coworkers such as the formation of an all female softball teams, lingerie, and house ware parties. A survey of reading materials on female-dominated nursing units found women’s magazines and Avon catalogues that were contained order forms (Flöge & Merrill, 1986).

Topics of conversations between nurses who are male can be judged to be inappropriate or offensive to female coworkers. These conversations emphasize doing rather than process and frequently include the use of metaphors and male-style joking (Evans, 2002; Farrell, 2005). Sometimes these topics include descriptions of hyper-masculine identities that often signal a heterosexual identity and a waylaying of homosexual orientations (Dyck et al., 2009; Yoshimura & Hayden, 2007). Researchers have stated that these conversations occurred as part of male socialization and as an affirmation of masculinity to create male bonding (Evans; Farrell).

Nurses who are male were found to converse with more ease and associate with male physicians who generally regarded nurses who are male as coworkers instead of subordinates. Nurses who are male and male physicians tend to greet one another and joke with each other. It has been hypothesized that male doctors believe that males who are nurses are more competent at their jobs than female coworkers. Nurses who were female were more frequently asked to get coffee or asked to assist patients to use bedpans by male physicians than nurses who were male. Differences in communication that took

place between doctors and nurses have been noted as nurses who were female were generally more passive in making recommendations to doctors and nurses who were male voiced opinions to doctors more readily. Male doctors were seen as asking nurses who were male for their opinions of patient care situations (Floge & Merrill, 1986). It was stated by Yoshimura and Hayden (2007) that the communication patterns of nurses who were male were also valued by administrators and managers.

Token Status

Although some nurses who are male may try to blend into the work environment, it has been found that they tend, in general, to be more visible to other nurses, supervisors, physicians, and patients' families (Floge & Merrill, 1986). This phenomenon was described by Kanter (1977) as token status which is the imbalance in the numbers of one sex over the other in the work setting. Token status and the practice of discrimination have been found to occur when sex population ratios reach up to 85:15 or higher. The sex that has the larger number in the workplace becomes dominant and controls the group and its culture. The members of the minority group are labeled as tokens and are subject to high visibility, contrast or polarization with exaggeration of differences, and assimilation of individuals to fit into stereotypical roles associated with their group. People who have token status often reported performance pressures, uncertainty about their acceptance, and feelings of being over protected or abandoned.

Junior and senior male nursing students who were interviewed by Paterson, Tschikota, Crawford, Saydak, Venkatesh, and Aronowitz (1996) related that they stood out in a crowd because of their gender minority. They stated that they believed that this heightened visibility was disadvantageous at times because their performances were

“under a microscope”. Another concern that was voiced about the increased visibility was the rumors and gossip that are spread especially in the area of budding romances when they were observed spending social time with individual classmates, nurses, and nursing instructors. Nurses who are men are associated with manual handling and are perceived to have more strength so they are often called upon to help lift patients, catheterize male patients, or to help deal with confused patients (Milligan, 2001; Poliafico 1998).

Evidence has shown that males are not a powerless, socially isolated group of tokens within the profession of nursing. Society’s elevation of males tends to persist in that line of work even though men constituted the minority group of this occupation. Sexism from within nursing tends to favor males (Stott, 2004). Simpson (2004) noted that almost all of the male participants interviewed in a research study recognized that their status as men gave them greater authority than their female counterparts. Floge and Merrill (1986) noted that some patients tended to respond more readily to male voices and that some patients have stated that nurses who were male modeled more characteristics of authority. The names of nurses who were male, the units where they worked, their shifts of duty, and aspects of their personal lives were more frequently identified by patients’ families than those of nurses who were female. Persons who were searching for a nurse tended to gravitate towards nurses who were male that were present on nursing units. An example of this behavior included an incidence when a family member went around a nurses’ desk and walked past several female nurses to ask a nurse who was male a question that could have been answered by any one of the nurses if any of them would have entered the room where the patient was located. A second example that was cited was when a patient was brought back to the unit from the X Ray department

and the transport orderly informed a nurse who was male that the patient had been returned even though that nurse was not caring for that individual.

Kadushin (1976) stated that although males who were nurses encountered difficulties in the work place, there were clear and undeniable advantages of being part of the male minority in any female profession. Wharton and Baron (1987) stated that token males were likely to receive privileged treatment and male token subjects who were employed in predominantly female occupations perceived themselves fairly well off relative to other men. The token status in nursing has actually worked as an advantage for men in this field as a form of reverse discrimination in hiring and promotion situations (Porter-O'Grady, 2007). Williams, C. (1992) documented a preference for hiring men by nurse employers and many men indicated that they received preferential treatment because they were men. Male participants stated that they were channeled into more "masculine" specialties that could lead to better paying and more prestigious specialties (Williams, C.). Nurses who are male have been commonly seen as better workers by superiors. They have been reported to appear to be confident, leader-like, and decisive and it was cited that those traits opened opportunities for charge and supervisory positions. Nurses who are male are frequently given additional responsibility, authority, and are assigned leadership by their female coworkers (Floge & Merrill, 1986; Stott, 2004).

Sochalski (2002) noted that the only way to receive salary gains in the field of nursing was to pursue more education or to leave the bedside for other jobs such as administrative positions. Nurses who are male face invisible pressures to move up in their professions to more prestigious and better paying jobs. This phenomenon is called the

“glass escalator” (Williams, C., 1992). Men occupy a disproportionate percentage of administrative and supervisory positions in nursing (Fottler, 1976). An example of this statement was illustrated by Porter-O’Grady (2007) who noted that 50% of the leadership positions in Great Britain were held by men who constituted ten percent of the total nurse population of that country. Nurses who are female were noted to face the “glass ceiling” that consisted of invisible barriers to promotion in their careers that have been caused mainly by sexist attitudes of men in the highest positions of employing agencies (Freeman, 1990).

Challenges of Patient Care Encountered by Nursing Students and Registered Nurses who are Male

Caring

Caring is the essential element of nursing (Anthony, 2006). This vital component of the profession has many nebulous and elusive interpretations. When the nursing profession was first established the concept of care was closely tied to the image of a good woman or a good mother. The image of masculinity is not usually associated with caring ((Keogh & Gleeson, 2006; Pittman, 2005).

Modern definitions of caring usually consist of two components. One component is the skill of caring that is from the psychomotor learning domain which is the act of “doing for” others. The second component is the skill of caring that is from the affective learning domain and consists of the “feeling for” others in the provision of comfort and support (Clifford, 1995; Keogh & Gleeson, 2006).

Estabrooks (1987) described the intents of touch were to perform a procedure, to comfort a patient, or a combination of both in the provision of care to patients. That

researcher conducted a review of literature on touch and found very few sources addressed how to touch as a professional nurse. It was hypothesized that the lack of literature regarding that subject could be that touch was thought to be inherently female and little needed to be written about that foundational technique because females have dominated the profession of nursing.

Evans (2002), Okrainec (1990), and Whittock and Leonard (2003) reported an equality in a caring attitude and devotion to the profession by male and female nursing students. Okrainec described that despite the equality in a caring attitude between the sexes of the nursing students, one third of both groups reported that they believed that females were superior in their natural aptitude for nursing and that none of the students surveyed stated that males had a natural superiority in that area. Evans reported that the commonly held perception of a lack of caring behaviors by males who were nurses was reflective of the result of the comparison of male caring behaviors against the feminine standard of nursing.

Societal stereotyping has played an important role in the beliefs about male and female caring behaviors. The caring actions of nurses who are male are affected by the societal perceptions that men's ability to care is inhibited by their gender and that masculine identities are compromised by engaging in caring activities (O'Lynn, 2007b). In western societies males are typically socialized to limit visible expressions of emotions while the opposite behavior is expected of females. Research conducted by Evans (2002) reported that touch was identified by all male and female participants in the study as important, if not central, to their practice as nurses. Touch was acknowledged to be a practice that did not come naturally to the male interviewees.

Evans (2002) stated that women's touch is considered a natural extension of the women's traditional caregiver role and that men's touch is surrounded with suspicion that implies that the motives of nurses who are male for touching are not care-orientated but are sexual in nature. Nurses who are female are likely to display caring behaviors through touch and open expression of emotion. This demonstrative caring behavior is seen as "natural" for female nursing students to learn but it is viewed as "unnatural" for male students who have been socialized to limit visible expression of emotion and to use touch carefully for fear of implying sexual overtones (Anthony, 2004, 2006). Inoue, Chapman and Wynaden (2006) reported that males who were nurses struggled with popular stereotypical beliefs that have labeled them as homosexual or as having a strong curiosity about female nudity. That population also stated the need to minimize suspicions of being gay and the need to project an image of masculinity by adhering to the principles that men do not touch other men unless there was a legitimate need. Societal stereotypes that portray nurses who are male as sexual aggressors create suspicions those men who are nurses are at the bedside for reasons other than a genuine desire to help others. When this stereotype is compounded with the suspicion that the nurse is gay, there are suspicions in situations where there is intimate touching with women, men, and children. In situations where nurses who are male provide intimate care to children, the sexualization of men's touch fuels suspicion that nurses who are male are pedophiles (Evans).

Vulnerable Caregivers

The concept of touch can include the provision of intimate care to patients in nursing situations. Intimate care has been defined as providing physical care that invades

the patient's personal space and requires the removal of some parts of their clothing or entails a procedure that touched the client's genital area (Inoue et al., 2006). The provision of this type of care can lead to accusations of inappropriate behavior or sexual molestation. Evans (2002) stated that the fear of misunderstandings and accusations that caused male research participants to be cautious and vigilant in the provision of care. Nurses who were male believed that they would be unable to defend themselves against patients' accusations of inappropriate behavior. These beliefs combined with the stereotypical images males who were nurses lead Evans to coin the phrase "vulnerable caregivers". That researcher reported that this phrase did not arise only from perceptions of patients but also from female coworkers. One male research participant stated that he was reported to the supervisor by a female colleague after she observed him put his hand on the shoulder of a partially dressed female to comfort her. Another participant was accused of molesting a newborn boy by the father who discovered him changing his baby's diaper.

Farrell (2005) stated that when people reported that when they were faced with the possibility of being touched intimately, both sexes reported that they would prefer a woman. That author speculated that the combination of women's fear of men's sexuality and men's desire for female sexuality lead to that discrimination. This statement was reinforced by males who were nursing students who stated that it was generally acceptable for nurses who were female to touch male and female patients but it was not acceptable for nurses who were males to do the same (Evans, 2002). Chur-Hansen (2002) reported that patients tended to prefer a nurse of their own gender when situations were

intimate and are more accepting of either gender when the clinical scenario is not emotionally invasive.

Several factors derived from the data influenced nurses who were males when using physical touch during care interventions. These factors included the patient's age, the patient's health status, and knowing the patient (Keogh & Gleeson, 2006). Male research participants were more comfortable touching men who were acutely ill because the patients were too sick to care about what anyone did to them. They stated that older men were more comfortable being touched by another man because they were less "macho". The males felt uncomfortable touching young people in their teens whom they perceived to be preoccupied with the possibility that nurses who are male might be gay (Evans, 2002).

It does not matter whether the purpose of touch is to perform a procedure or to provide comfort and it is potentially dangerous for nurses who are male to meet the health care needs of patients, particularly women patients. Caring for patients of the opposite sex by males is an anxiety provoking and sometimes unnerving experience regardless of the area of clinical practice (Keogh & Gleeson, 2006). These researchers reported that there were general feelings of anxiety when caring for female patients by males who were nurses in their interventions that involved touch because they might be seen as sexually inappropriate. Evans (2002) stated that male research participants voiced concerns that female patients might be uncomfortable and/or misinterpret their touch. Inoue et al. (2006) studied nurses who were male and all of the respondents reported that they found the experience of providing care for women patients challenging. They stated that they were more aware of gender when providing care to younger female clients. The

nurses reported feelings of discomfort and embarrassment but overcame them by suppressing those feelings and focusing on the task at hand. The sexualization of touch of nurses who are male is evident in the area of obstetric nursing where the nature of touch is extremely intimate (Evans).

Learning to Care and Touch

Paterson et al. (1996) conducted a qualitative research study on male students who were enrolled in three different phases of nursing education. The study populations were beginning students, junior students, and senior students. Findings from the group of beginning students yielded no significant differences in caring between the sexes. The junior and senior students identified that males may care differently than female nursing students. The junior students related that the clinical learning portion of the curriculum entailed situations in which manifestations of caring that were previously invisible to them were now visible. They related that they had to learn aspects of caring that came “naturally” to their female classmates. They reported that they were hesitant to discuss caring concerns with female faculty persons because they thought that the faculty persons would not understand their caring situations. Junior nursing students stated that the female faculty and nurses expected them to care for patients “like women do”.

The students reported that they had to divest themselves of their “macho” image when providing care to patients because they learned all of their life that to display emotion was effeminate and emasculating behavior. The senior students stated that they had developed an understanding and acceptance of both female caring and male caring. They reported that male caring was less “touchy feely” and entailed more of a “friendship” than female caring. Rejection by patients to let the males provide care made

the respondents acutely aware that they were different. The juniors and seniors related that they worked on “appropriate” ways to touch patients so the patients don’t think that they are being seduced. Senior males stated that their caring practices were less demonstrative than female caring but that they felt just as equally connected (Paterson et al., 1996).

The males who were nursing students reported feelings of confusion, resentment, fear, and embarrassment when they made their first attempts to emulate female touch. They stated that they were not prepared for that experience. They stated that they had no mentors to listen to their experiences (Paterson et al., 1996).

Evans (2002) reported that male research participants related that the need to learn care and/or develop comfort with expressions of caring are essential to the provision of nursing care. Nursing students who are male must learn ways to demonstrate caring behaviors (Anthony, 2004, 2006). Keogh and Gleeson (2006) stated that not much emphasis was placed on physical touch as a nursing intervention in nursing curricula. Touch was generally not covered as a separate subject but was taught with communication and self-awareness.

Learning to care professionally may be experienced differently by male nursing students (O’Lynn, 2007b). Learning how to care can be an object of role strain for males who are nurses who are expected to take care of patients like women (Paterson et al., 1996). Inoue et al. (2006) reported that male nurses were not prepared to manage the feelings associated with the delivery of intimate care. Evans (2002) stated that one male research participant spoke of the newness of touching because it was not part of his existence prior to enrolling in nursing education. Male participants in that study also

reported dealing with the newness of touching with “caring hands” and learning to feel comfortable with others.

Men who were nurses reported that they used touch less than their women colleagues. One participant in that study characterized the difference between nurses who were female and male by describing women’s caring as “warm fuzzies” and more “touchy feely” (Evans, 2002).

The literature identifies many caring strategies commonly utilized by males who were nurses who provided direct care to patients. Evans (2002) cited that most male research participants identified camaraderie and humor as important expressions of their caring practice. Nurses who were male stated that they thought that the use of humor added warmth to help male and female patients to relax and to establish comfort more frequently than nurses who were female. Humor was used with male patients as a means to relieve male anxiety. It was stated that the use of humor was used as a comfortable approach to male patients and a way to be a friend or a buddy to them (Evans). The use of humor was used in conversations with female patients and males who were nurses believed that the use of humor was an effective way to establish a good nurse-patient relationship (Inoue et al., 2006).

Other self-protection strategies for men who were nurses to protect themselves from sexual allegations included not engaging in interventions on female patients that were deemed intimate and asking nurses who are female to perform procedures if women patients reacted negatively toward them. The presence of a female chaperone while performing caring procedures was used by the males when providing care to avoid the possibility of misunderstandings, suspicions, and/or rejection from women clients and

their families when delivering intimate care to female patients (Inoue et al., 2006).

Nursing students who were male stated that they found themselves doing postpartum checks in an “extra” professional manner. They reported that this behavior helped to put themselves and their patients at ease for that period of time (Patterson & Morin, 2002).

Some nurses who are male were reported to gravitate to work in areas that involve less intimate touch to avoid uncomfortable situations (Egeland & Brown, 1989; Kauppinen-Toropainen & Lammi, 1993). Evans (2002) concluded that the majority of male research participants who were nurses acknowledged that the expressions of caring, touching, and comforting others as rewarding for them and their patients even though these techniques were new to them.

Summary

The role of men in the history of nursing does have a very unique story that is literally unknown by the general public and by the majority of registered nurses. The review of literature revealed that the virtual absence of men in the profession of nursing over the last 150 years has been examined by few nursing scholars. The under representation of men in nursing has historical roots that can be traced to the advent of the Industrial Age and to Florence Nightingale who is commonly known as the founder of the modern nursing profession. The Victorian influence of Florence Nightingale continues to have a profound effect of the profession of nursing and on the public’s view of the image of the nurse. The division of labor and the sex typing of professions have deep roots that continue to be embedded in industrialized societies. These traditional beliefs often go unchallenged and generalized society-driven traits that should be labeled as gender roles are mistakenly associated with the physical characteristics of sex by many

people including well known authors. Despite advances in equality between the sexes in the workforce, the profession of nursing is still strongly considered to be a “woman’s profession”. Societal stereotypes continue to shroud men who choose to become nurses. Male nurses are sometimes the subject of ridicule of their friends or they are questioned by patients regarding their motives to provide intimate cares. Men who choose to become nurses often face unique challenges of working in a female-dominated profession but also often benefit from having minority token status when they receive favor because of their sex. The literature review revealed that a limited amount of research has been conducted on the lived experiences of men who choose to become nurses and further exploration of these experiences can help with recruitment efforts and retention of men who enter the profession of nursing.

CHAPTER III

DESIGN AND METHODOLOGY

This study was designed to understand perceptions of males who were nurses. The purpose of this study was to gain “first hand” perspectives from men who worked in various roles the female-dominated profession of nursing that included the provision of direct patient care. The data from the interviews was obtained to gain insights from professional and personal experiences from this minority population within the nursing profession. This chapter consists of: Qualitative Research Design, Phenomenology, Data Collection Procedures, Interviewing, and Data Analysis Procedures.

Qualitative Research Design

The knowledge about human experiences arises from descriptions given by humans and qualitative research studies tell a story (Parse, 2001; Patton 2002). This study utilized the qualitative research paradigm because the characteristics of this type of research methodology closely aligned with the intent of this study. The purpose of the study was to describe and explore the lived experiences of a sample of nurses who were male and practiced in various roles that included the provision of direct patient care. This study explored the perspective of males who were nurses, utilizing the qualitative research method, in an effort to obtain a detailed understanding of their experiences regarding their choice of career, their educational experiences, their work experiences, and their evaluation of their choice of career. The qualitative paradigm was fitting to this research question in that it utilized methods that were used to understand the social

phenomena from perspectives based on the experiences of males who were nurses who provided direct patient care as part of their various roles in nursing. Issues brought forth by the data received in this research study can be examined in their context of the participants' particular socio-cultural-political milieu by all nurses particularly nurse educators and nurse managers. These issues can be used to transform or change social conditions to help address the nursing shortage especially in the areas of recruitment and retention of men (Glesne, 2006).

The open-ended questions used for this study were designed to obtain data from participants who experienced "real life" experiences in the profession of nursing on an everyday basis. This type of interviewee was deemed to be an original rich source of information for this study by the researcher regarding recruitment and retention of men in the profession of nursing. The qualitative research paradigm is utilized by researchers who need to listen to the views of the participants in research studies by asking general open questions to discover knowledge. The researcher who conducts qualitative research often has a role in advocating for change and bettering the lives of individuals (Creswell, 2005, 2008).

Nursing is a human science discipline as it is both an art and a science. Tenets of qualitative research are very compatible with the philosophical underpinnings of the nursing profession in the discovery of personal and aesthetic knowledge (Hek, Judd, & Moule, 1996). Prior to 1960 most nurses who were prepared at the doctorate level attended schools of education and there were few studies conducted to help establish nursing theory and research (Jacox, Suppe, Campell, & Stachinko, 1999). Qualitative research methods became formally recognized and utilized in the design of nursing

research studies in the mid 1970s. Quantitative research designs were identified to be the only valid means of obtaining data to promote nursing knowledge prior to this time (Munhall, 1994). Qualitative research methods are used to obtain more valid information from individuals who may feel silenced or ignored by more standardized survey techniques (Williams. C., & Heikes, 1993). Qualitative researchers obtain first-hand knowledge that is unfiltered through operational definitions or rating scales and all perspectives are worthy of study (Taylor & Bogdan, 1998).

The qualitative research paradigm portrays the world as the place in which reality is socially constructed, complex, ever changing, and relative (Glesne, 2006; Lincoln & Guba, 2000). The person comes to know those realities through interactions and subjective explorations about their perceptions (Glesne). The findings that are obtained in qualitative research are obtained from interaction with others. The data that is collected is subjective in nature and can not be externally measured (Lincoln & Guba). The qualitative researcher does not start with hypotheses at the initiation of research studies and needs to keep an open mindset to the variety of perspectives and issues that might arise during the interviews. The researcher becomes the main research instrument through observation, questioning, and interactions with the research participants. The researcher looked for patterns in the data to attempt to find tentative conclusions to aid in the recruitment and retention of men in the nursing profession. The final write up for this type of research is descriptive in nature with minor use of numerical indices (Glesne).

Qualitative research designs generally have the following features of a holistic approach to questions with recognition that human realities are complex and the focus of the research is on the human experience. These research strategies generally include the

feature of sustained contact with people in settings where those people normally spend their time with careful attention to the contexts of human behavior and there is typically a high level of researcher involvement with subjects. Features of this type of research include participant observation and in-depth unstructured interviews which can be guided by questions. The data produced by this type of research provide a description, usually narrative, of the people living through events or situations. These features enable the qualitative researcher to obtain rich, descriptive data that help others to understand those persons' lived experiences. The emphasis of qualitative research is to achieve understanding that will open new options for action and new perspectives that can change people's lives (Boyd, 1993).

Qualitative research methodologies aim to provide an in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, perspectives, and histories (Snape & Spencer, 2003). The emphasis of this type of research methodology is on the qualities of entities as well as on processes and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity, or frequency (Denzin & Lincoln, 2000). Lincoln and Guba (2000) noted that this type of research portrays reality as a multiple, constructed, interdependent whole that cannot be broken down into measurable segments.

Qualitative research evaluates an intervention in a specific context with no immediate expectation for generalization (Crabtree & Miller, 1999). All events, phenomena, and situations are bound by time and context so that generalizations are not possible in qualitative research. This type of research methodology seeks answers to

questions that stress how social experience is created and given meaning (Denzin & Lincoln).

There are three assumptions that underlie qualitative research methodology. They are 1) “humans create social networks 2) humans can describe retrospective and prospective life events and 3) patterns and themes surface through intense study of phenomena” (Parse, 2001, p. 57). This type of research methodology is primarily utilized in the areas of social or human sciences to understand subjectively meaningful experiences (Munhall, 1994; Snape & Spencer, 2003).

Qualitative research designs are generally associated with the constructivist paradigm. The focus of the constructivist paradigm is individual construction of social reality (Denzin & Lincoln, 2000). Researchers seek to understand and interpret how the various participants in a social setting construct the world around them (Glesne, 2006). This paradigm promotes the assumption that access to reality is only through social constructions such as language, consciousness, and shared meanings (Myers, 1997). The premise of this paradigm is that the human world is different from the natural, physical world and must be studied differently (Patton, 2002). Human beings construct their perceptions of the world that no one perception is right or more real than another and that truth is relative to the perspective of the person (Crabtree & Miller, 1999; Glesne). Crabtree and Miller stated that this method of inquiry facilitated researchers to discover knowledge that helped humans maintain cultural life, symbolic communication, and meaning. Data for this research paradigm are obtained through the processes of looking, listening, and engaging.

Munhall (1994) described the following ethical assumptions of qualitative research methods:

- 1) Human beings are as they are and there is no preplanned effort to change individuals or groups. The data collection effort is directed toward discovery and understanding of the experience. 2) The actions of individuals are in some sense free – they are free to be who they are. 3) There is a reverence for the human experience as a new and fresh experience and the descriptions derived contribute to the ability to understand and to be empathetic. 4) The researcher does not predetermine reality through their own assumptions. 5) The research subjects are the authors of their biographies and experiences and 6) The researcher must have reverence for the subjective, self-determined, self-described realities of individuals and groups. (p. 11)

The researcher for this study met five out of six of these ethical assumptions. The researcher did not completely meet the fourth assumption that addressed the predetermination of reality through by the researcher's assumptions. There was a potential of bias on the part of the researcher because of personal and professional contacts with some of the participants in the study prior to the interviews. The rigor and safeguards that were taken by the researcher to minimize potential bias so that clear discovery could be obtained from the data are described on pages 88 and 89 of this study.

Phenomenology

Parse (2001) described that the purpose of the phenomenological method was to discover structures of lived experiences to shed light on their meaning. The goal of this type of research is to study the essence of experiences to arrive at a comprehensive description of the phenomenon under study (Munhall, 1994). The phenomenology design was chosen for this research study because of the compatibility of its purpose with the overall focus of this project. This study was designed to explore the life experiences and perceptions of the profession of nursing of nurses who were male and worked in various positions that included the provision of direct patient care. The purpose of this

exploration was to gain insight from this underrepresented population to help with recruitment and retention efforts as the nursing profession faces a workforce shortage (Boyd, 1990).

Phenomenology is used to gain knowledge within the experience of the individual and the individual's view of the world (Hek et al., 1996). A phenomenological study is conducted to understand the lived experience of individuals and their intention within their life world (Crabtree & Miller, 1999). This type of research design describes the meaning for several individuals of their lived experiences of a concept or phenomenon (Creswell, 1998, 2007; Grbich, 1999). It is a method of qualitative research that relies on description to enhance the understanding of human experience as they are lived (Parse, 2001). The purpose for this type of research is to uncover the meaning of how humans experience phenomena through the description of those experiences as they are lived by individuals (Creswell, 1998; DePoy & Gitlin, 1998). This type of research is used to understand the sense that a given situation bears for person to grasp something of the person's reality and it is a way to see what is true from his or her viewpoint. The human experience is the human involvement in a situation before interpretation of the experience occurs (Boyd, 1990). This type of research is a method of discovery and not of verification (Parse). The researcher derives a composite description of the subjects about what and how they experienced the phenomenon (Creswell, 2007).

The knowledge about human experiences arises from descriptions given by humans (Parse, 2001). This study explored perspectives of males who were nurses regarding their choice of career, their educational experiences, their work experiences, and their evaluations of their choice of career. The phenomenological approach was

fitting to the purpose of this research project in that its methods were utilized to understand the social phenomena from the perspectives based on the experiences of males who were nurses who worked in various roles that included the provision of direct patient care. Issues brought forth by the data received in this research study can be examined in the context of the participants' particular socio-cultural-political milieu by all nurses, particularly nurse educators and nurse managers. These issues can be used to transform or change social conditions that can affect recruitment and retention efforts of men help address the nursing shortage (Glesne, 2006).

Data Collection Procedures

This research study was approved by the University of North Dakota (UND) Institutional Review Board (IRB) February 7, 2008 as an expedited review. The forms of acceptance for this approval are contained in Appendix A. The application was resubmitted for an annual review to the UND IRB Board January 2009 and it received another annual approval at that time.

The general research question that was developed for this study was: What are the life experiences of male professional nurses who worked in a variety of roles that included the provision of direct patient care? The researcher developed a conceptual model in the form of a Venn diagram (p. 82) for the study that guided the development of the interview guide. This type of diagram was used to depict the holistic view of the population of registered nurses who participated in the study. The researcher recognized that these persons were multifaceted and that their individual lived experiences would be the result of the integration of various professional and personal socialization life experiences that were informally deemed by the researcher to commonly occur during the

process of becoming a registered nurse. The intersecting circles contained in the model represented these common experiences. The socializing phases were identified as sections for the interview form and broad subset questions were developed to guide the interview. The model was critiqued by fellow doctoral students and the professor who was teaching an advanced qualitative research methods class. This model is illustrated in Figure 1 (below).

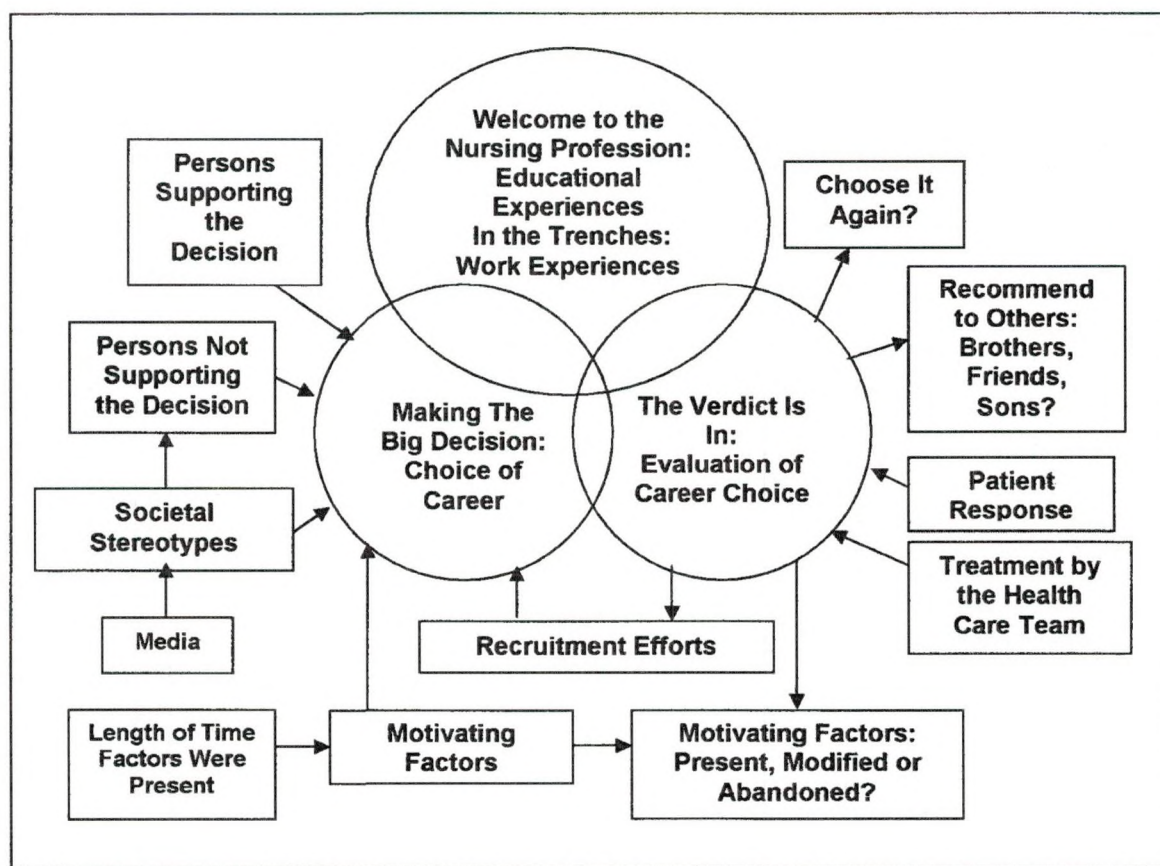


Figure 1. Male Nurses' Perspectives on Their Career Choice: Conceptual Model for the Interview Guide

Major sections that were identified for the interview guide were: Making the Big Decision that included eliciting information regarding the choice of the nursing profession, Welcome to the Profession that included obtaining data that concerned

nursing educational experiences, *In the Trenches: Work Experiences* that included recollections of professional work experiences, and *The Verdict Is In: Evaluation of Career Choice*. The subset questions that related to the major sections were then developed by the researcher. The questions were critiqued by a doctoral student in an advanced qualitative research course and by a professor who had expertise in the field of qualitative research. A copy of the guided interview is contained in Appendix B.

The questions for the interview were categorized as Level One Questions which elicit descriptions of a single topic or a single population (Brink and Wood, 1988). This category of question is exploratory in nature and its intent is to describe what is found. This type of question is asked in natural settings to describe what exists as it exists. This type of question is asked in a manner that will lead to exploration by the researcher and result in a complete description of the topic. At this level there is little or no prior knowledge of the topic.

The questions that were developed for the interviews were broad in nature. Broad questions were used to elicit information about the subjects' experiences about the phenomenon. Open-ended questions gave the researcher the opportunity to listen carefully to what the interviewees have to say (Creswell, 1998, 2007).

A pilot study for this research project was conducted as part of an advanced qualitative methodology course during the spring semester of 2008 on four nursing students who were male. Data collection for this dissertation began after the topic proposal was approved October 22, 2008 by the researcher's dissertation committee.

The sampling method that was used for the pilot study and this study is described as "purposeful" by Creswell (2008). The researcher, with this type of sampling,

intentionally selects individuals to learn or understand the central phenomenon. The type of sample design that was selected for this study, before data collection occurred, was homogeneous sampling that is used to describe some subgroup in depth. The intent of this research was to describe the experiences of the subgroup of male nurses that provided patient care to gain perspectives about the profession of nursing.

The use of snowball sampling, a type of qualitative research purposeful sampling method, was also used by the researcher for this study after the data collection started. Initial interviewees were asked to recommend other individuals to participate in the study (Creswell, 2005, 2008). Six of the male nurse interviewees worked in two different critical care areas of an acute care setting where the researcher supervised nursing students' nursing practice experiences and five of these interviewees were known to the researcher on a professional basis. Those first interviewees recommended other men to interview. The researcher also purposely tried to obtain stratification of the study sample by obtaining the names of additional potential participants to gain perspectives from other men who worked in a variety of patient care areas other than those critical care areas.

The twelve registered nurses who participated in this study were personally approached by the researcher to obtain verbal consent to be contacted for an interview. All of the potential interviewees who were asked to participate in the study verbally agreed to be interviewed for the study. The researcher then gave each potential interviewee an information sheet that described the purpose of the study and a copy of the informed consent form. A copy of this information sheet is contained in Appendix C and a copy of the informed consent form is contained in Appendix D. The participants shared contact information with the researcher and the researcher then made follow up contacts

to schedule interviews at times and places that were mutually convenient for the interviewees and the researcher.

The researcher delineated ideas, knowledge and biases about the interview subjects in writing before the initiation of the data collection to help eliminate bias so that new thoughts and ideas could be received from the participants during the interview process. The process of suspension of this knowledge is known as bracketing (Creswell, 1998, 2007; Creswell & Miller, 2000).

The majority of the interviews occurred in public places as four were in the Barnes and Noble book store, three were in the Barnes and Noble coffee shop, two were in restaurant settings, two were in homes of the interviewees, and one was conducted in an unused lounge area in the YMCA. Each participant was given two identical consent forms to read and sign before the interview began. The interviewer retained one of the consent forms and returned the second signed consent form to each of the interviewees. The participants were also asked for verbal consent of the interviewer to use two digital recorders to use during the interview. The researcher wrote notations, observations, and pertinent data on a legal tablet during the interviews.

Interviewing

The emphasis of the use of communicating to research participants through the technique of interviewing is the strength of qualitative research. Interviewing is the most widely used technique for conducting systematic social inquiry as it provides a way of generalizing empirical data about the social world by asking people to talk about their lives (Holstein & Gubrium, 2003). Interviewing is a form of naturalistic inquiry that occurs in real life settings and the researcher does not attempt to manipulate the

phenomenon of interest (Patton, 2002). This technique has an interest in understanding the lived experience of other people and the meaning they make of that experience. This interviewing technique is an inductive, emerging, discovery oriented, and dynamic process (Creswell, 2007; Seidman, 2006).

The data collection procedure that was used for this study was the interview technique. This technique was used for this study because of its use in obtaining data for qualitative phenomenology research studies. Data is collected from persons who have experienced the phenomenon that is selected to be studied by the researcher through the interview process. Exploration of the research problem occurs rather than the use of predetermined information from the literature (Creswell, 2007). Data collection consists of in-depth or multiple interviews. Individuals, in their own right, are accepted as significant commentators on their own experience. Each individual has significant views and feelings about life that are accessible to those who choose to interview them (Holstein & Gubrium, 2003).

The type of interview that was used for this study was the one-on-one interview. This type of data collection process occurs when the researcher asks questions and records answers from only one research subject at a time. This type of interviewing technique is ideal for interviewing participants who are hesitant to speak, are articulate, and who can share ideas comfortably (Creswell, 2008).

Twelve interviews were completed for this study. The interviews were conducted until theoretical saturation of the data was obtained. Saturation occurred when additional analysis no longer provided new information that could be added to the major themes that were identified (Creswell, 2008; Strauss, 1987). The average length of the majority of the

interviews was approximately 65 minutes in length and the time of the interviews ranged from 55 minutes to 105 minutes. Fictional names were assigned to the interviewees.

Data Analysis Procedures

The purpose of data analysis is to bring meaning, structure, and order to the data. The interpretation of data requires an acute awareness of the data, concentration, and openness to subtle undercurrents of life. The researcher must transfer what has been learned into a body of textual work that communicates the research findings in an understandable manner to the reader (Anfara, Brown, & Mangione, 2002).

The process of analyzing the text in qualitative research is called the process of coding. Coding is the process of segmenting and labeling text to form descriptions and broad themes in the data. The object of this inductive process is to make sense out of the data but narrowing it into a few themes. The coding process consisted of dividing the data into segments with codes, examining the codes for overlap and redundancy, and collapsing the codes into broad themes. Data that were pertinent to the themes were then utilized and data that were not pertinent to the themes were disregarded (Creswell, 2005). The codes were divided to coincide with the major sections of the interview guide. These major sections were Choosing Nursing as a Career, Educational Experiences, and Work Experiences.

The first step of data analysis in phenomenology research is the critical study and analysis of the data for significant statements which are sentences or quotes that give the researcher an understanding of how the participants experienced the phenomenon. This step is called horizontalization. Each horizon is the grounding or condition of the phenomenon that gives it a distinctive character (Moustakas, 1994). Clusters of meaning

are then developed from the significant statements and these meanings are compared with the data so that the original intent of the meaning of the data is present. A textual description is then written to describe what the participants experienced (Creswell, 2007; Moustakas).

Data analysis of qualitative phenomenological research is a reflective activity for the researcher. The researcher may write a structural description of the study which is a description of how the setting influenced how the interviewees experienced the phenomenon (Creswell, 1998, 2007). The researcher may write memos while doing the data analysis to capture analytic thinking about the data but to also facilitate the formation of analytic insights (Maxwell, 2005). The researcher must also practice reflexivity which is composed of examining self-awareness, political/cultural consciousness and ownership of one's perspective in the research process, and analysis of the data. This process involves self questioning and self-understanding of the researcher's own biases, values, and assumptions to actively discuss his or her roles or experiences in the discussion of the research procedures, in the conclusion of the research or in an epilogue (Creswell, 2005; Patton, 2002). The qualitative researcher who utilizes the reflexive process takes time to step back to let the imagination and the unconscious work in the coding of the data (Marshall, 2002). A personal narrative can be written to describe research experiences, the context, and situations that surround this experience as part of the reflexivity process. The researcher did complete the reflexive process for this project after auditing the transcripts for accuracy and the interjection of observations made by the researcher during the interviews prior to the coding of the data because of possible bias that could be associated with knowing some of the interviewees on a professional basis.

Computer assisted qualitative data analysis systems (CAQDAS) are often used by qualitative researchers to search, organize, categorize, and annotate textual and visual data. The data associated with qualitative research is often complex and these types of systems can enable the researcher to efficiently code data and to manage large volumes of data (Creswell 1998; Marshall, 2002). The *Ethnograph* computer assisted data analysis program was utilized for analysis of the qualitative data for this study. The *Ethnograph* is a code and retrieve software program that was designed to facilitate the processing of qualitatively gathered data by helping to compile, organize, and manipulate data. It can take over most of the mechanical tasks that are required in the manual handling in the analysis of qualitative data so that the researcher is free to concentrate on the analytical or thinking parts of the research. This program aids in the grouping of the data to help the researcher establish relationships among the data (Aljunid, 1996; Seidel & Clark, 1984). The researcher utilized this computer assisted program to code the data, to define each code, and to create a code tree that showed the relationships among the codes. The researcher was able to view the number of times each code was assigned to each interviewee. The researcher searched the codes from all of the interviewees' transcripts to assist with the reporting and the analysis of data for this study. Figure 2 (p. 90) contains a concept map of the codes, categories, themes, and final assertion for this study. The data that is the foundation for this chart is described in detail in Chapter 5 "Interpretations..." The conclusion of the data analysis for qualitative phenomenological research is the merging of the textural and structural descriptions into one document that describes the core of the phenomenon and larger abstract meanings of the data analysis are presented.

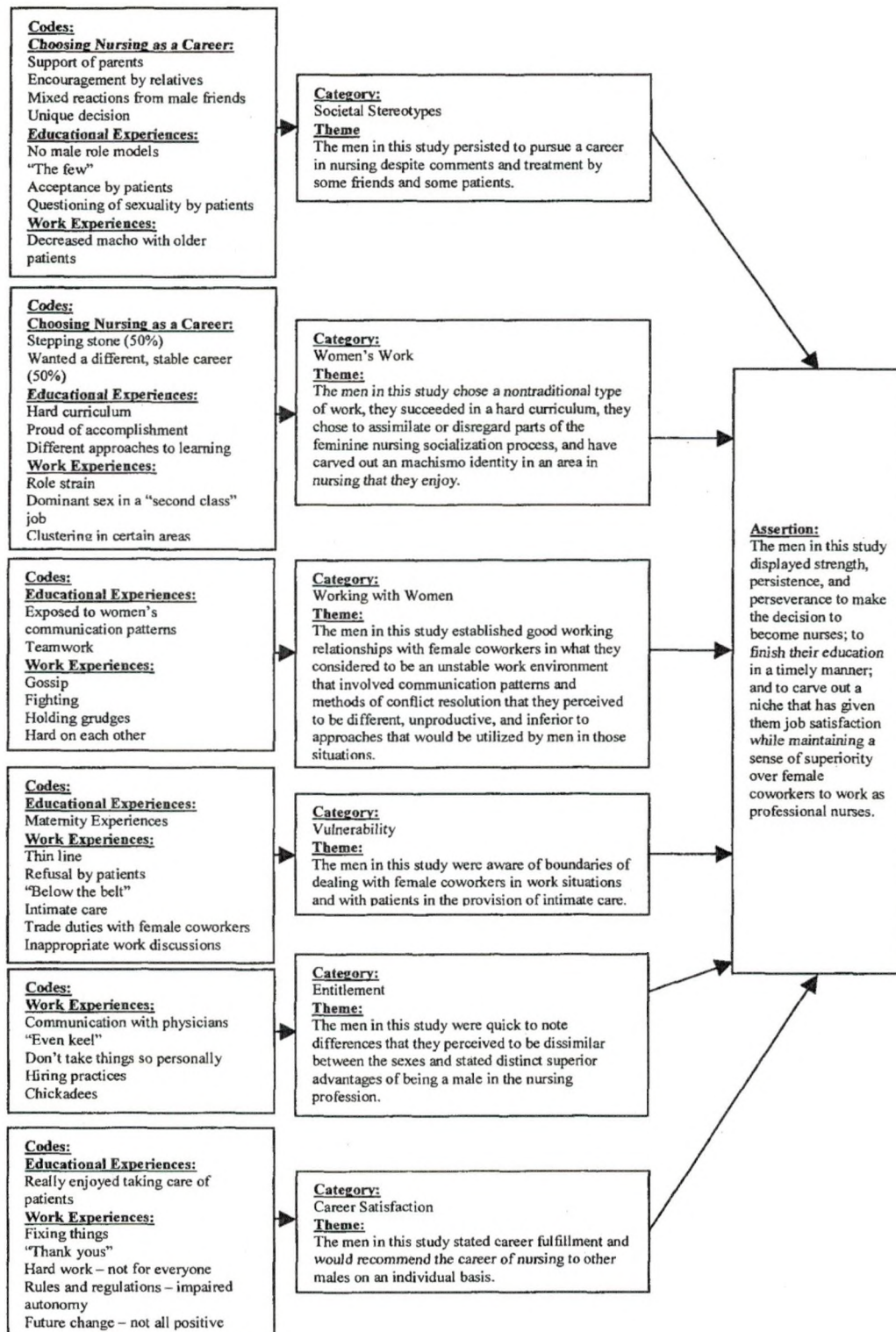


Figure 2. Identification of Codes, Categories, Themes, and Final Assertion

The document is shaped by the researcher's experience in collecting and analyzing the data (Creswell, 1998, 2007).

Validity issues address the trustworthiness of research projects so that the researcher can draw legitimate conclusions from the sample (Creswell, 2008; Glesne, 2006). The researcher has the responsibility to document the actions associated with establishing internal validity, theme development, and the relationship between the research questions and the data sources. Internal validity is concerned with how trustworthy the conclusions are that are drawn from the data and the match of these conclusions with reality (Anfara et al., 2002).

Eight verification procedures have been described that could be used to validate qualitative research and at least two of the following procedures should be utilized to establish validity. These procedures include prolonged engagement and persistent observation, triangulation, peer review or debriefing, negative case analysis, clarifying researcher bias, member checking, thick, rich description, and external audits (Creswell 2008; Creswell & Miller, 2000). It is recommended that qualitative researchers engage in at least two of these eight verification methods in any given study (Creswell, 1998). The researcher employed some of these verification methods to ensure internal validity of the study. The first procedure of prolonged engagement and persistent observation occurred with approximately one half of the research participants through the supervision of nursing students in areas of the participants' employment. Those nurses were observed in their natural work setting by the researcher since they began employment at the medical center. The researcher also read students' papers that reflected the professional milieu of these supervised areas. The students frequently included comments about the

psychomotor, affective, and cognitive skills utilized by specific nurses and the names of the interviewees were sometimes included in these comments. A peer debriefing was conducted by the dissertation committee chair. This expert in the area of qualitative research received a copy of the final draft of the transcripts for review and met with the researcher to review the completed analytic coding scheme that was created from the data. The researcher also did make notations about the subjectivity that could occur during the research process prior to the interviews. The researcher was very careful not to interject comments and to use neutral body language during the interview process so that the participants could fully share their experiences that would be free of any input from the researcher. The researcher became immersed in the data while adding rich, thick descriptions to the transcriptions after the accuracy of the transcriptions was ascertained. The researcher's comments, personal reflections and questions were added to the interview transcripts in a separate column beside the data. Observations that directly impacted the data were placed in the data column with parentheses to contextualize the data of the research study.

The concept of reliability implies that the data should be consistent and free of error (Creswell, 2008). Reliability in qualitative research is enhanced when the researcher obtains detailed fieldnotes with a good quality tape and by transcribing the tape. The digital recordings of each interview for this research project were transferred to two compact discs. One of the compact discs was given to a transcriber and one was kept in a fireproof safe. The transcriber returned the compact disc of each interview to the researcher and emailed the interview data to the researcher. These typed interviews were saved in the researcher's word processing system for ease of editing. The transcribed

interviews were checked a minimum of three times to ensure that the transcriptions matched the interview data. A research assistant initially compared the transcribed interviews to the compact disks for accuracy. The assistant made notations on the interviews to suggest possible changes. The researcher then compared the typed interviews to the compact discs twice. The first time the researcher corrected typographical errors on the transcripts and the second time the researcher compared the written notes that were made during the interviews to the compact discs and added details to the transcripts that included pauses, speech patterns, body language, and eye contact.

The interpretation of the data occurs when there is reference to the literature and post studies to show how these interpretations may support and or contraindicate prior studies. In qualitative research the literature review plays a less substantial role at the beginning of the study. Literature is reviewed to study the research problem and it does not provide major direction for the research questions. This strategy is used so that the researcher will rely on the views of the participants and less on the direction identified in the literature selected by the researcher (Creswell, 2008).

A brief overview of the review of literature was prepared to develop the proposal for this project. The extensive literature review that is contained in Chapter 2 of this dissertation was conducted after all of the interviews were completed and the data was coded.

CHAPTER IV

FINDINGS

This chapter will discuss the findings that were received from the interviews. Background data as well as discussion of the data that was obtained under the interview sections of Making the Big Decision: Choosing Nursing as a Career, Welcome to the Nursing Profession: Educational Experiences, In The Trenches: Work Experiences, and The Verdict Is In: Evaluation of Career Choice will be presented.

Background Data

The sample for this research study was comprised of twelve males who worked in various roles that included the provision of direct bedside care to patients as registered nurses. All of the participants for this study possessed a minimum of a baccalaureate degree in nursing and one of them had a master's degree at the time of the interviews. This sample of nurses worked in two acute care facilities that were located in a city in the central portion of a Midwestern state.

The twelve participants, who appeared to be Caucasian, graduated with baccalaureate degrees in nursing from four colleges from the same Midwestern state. The colleges consisted of three private schools located in the central to eastern portion of the state and one was a public university located in the northeastern part of the state. Eleven of the twelve subjects initially enrolled in and graduated from four year nursing degree programs. One of the twelve interviewees utilized a career mobility track and was a licensed practical nurse (LPN) prior to enrolling in a baccalaureate nursing program.

William gave the following narrative to explain why he continued his education from licensed practical nurse (LPN) to registered nurse (RN):

At the end of my sophomore year [name of an LPN school] my wife did a very foolish thing she got pregnant all by herself [Said in a joking manner]. And so, we had planned when we came to town she would have a little job and I would have a little job between the two of us. But, when she couldn't work for what I could see for a long time, I said, "I've got to have more money then ten bucks an hour" and so I thought I have to go for two more years. And so they took me – I just kind of at the last minute – I was surprised that they still had room in the program, because I didn't apply until about May. I was graduating [from the LPN program] – they took me for the fall. So I went through that. (personal communication, November 25, 2008)

Three of the interviewees entered college at the traditional age of eighteen with the declared major of nursing and graduated in four years. Three participants entered college at the age of eighteen with different majors and switched to nursing after one semester. Two of these interviewees who switched majors declared physical therapy as their original college majors and one was enrolled in an athletic training program. One of the three participants who switched college majors graduated in four years and the other two completed their programs of study in five years. All six of these nurses entered college immediately after high school were not married and did not have any children when they entered and graduated from college.

Three of the respondents made the decision to become a nurse prior to entering college. Two of these participants stated that they wanted to be nurses in high school and one made his career decision in middle school. The decision to become a nurse did not come at an early age for half of the respondents. This statement was illustrated by Jack (personal communication, November 28, 2008) who stated "I initially got into nursing was more by default than anything. It wasn't something I went through high school thinking, 'Oh, I'm going to become a nurse', that wasn't it, no." The decision to enter the

profession of nursing at a later time by the men was contrasted to the timing of the decision of women by Patrick who illustrated this point when he talked about starting his nursing education with his wife:

No, we kind of, we actually started at the same time. [Paused] And I kind of tried to discourage her to be a nurse, I don't know why, I just did, I thought maybe she should go into something different but she was like, you know what, ever since I was a little kid, I wanted to be a nurse and so we both applied at the same time. (personal communication, December 10, 2008)

The remaining six interviewees entered the field of nursing at a later time after working at other jobs and some of the subjects held several jobs prior to enrolling in nursing education. This variety of occupations that these participants held did not necessarily include exposure to health care. These jobs included mechanic, motorcycle mechanic, farmer, hospital phlebotomist, music teacher, salesperson, real estate agent, hospital orderly, army medic, and gun shop owner. All six of the nurses who had a late entry into the profession of nursing were married at the time that they enrolled in school and four of the married students also had at least one child at the time of entering nursing education.

At the time of the interviews eight of the nurses were married, two were engaged to be married, and two were divorced and not remarried. The two who were divorced were older students who were married at the time that they entered school.

The years of experience of the sample as registered nurses ranged from .5 years to 24.5 years. The mean of the years of experience for this group was 10.3 years and the median was 11 years. Six of the subjects had a minimum work experience of 11.5 years as registered nurses.

Eight of the participants worked in critical care areas. Four of these nurses worked on a telemetry unit, two in an intensive care unit, and two in emergency rooms in different facilities. All of the remaining participants each worked in the areas of psychiatry, dialysis, the operating room, and in a flex pool that encompassed the areas of medical/oncology, psychiatry, rehabilitation, and transitional care at the time of the interviews.

One of the subjects who received a master's degree in management was in the process of moving into an assistant administrative position in the operating room at the time of the interviews. A second participant was in the process of obtaining a master's degree in nursing education and anticipated that he would continue to work as a staff nurse after graduation. This participant held a dual role of staff nurse and clinical adjunct faculty for a local university in the psychiatry unit. Both of these nurses received this advanced nursing education from a local university.

All of the participants worked full time as registered nurses. In addition to their full time employment commitments, three of the interviewees held second and third jobs. Jonathan worked very infrequently on a "help out" basis at a rural hospital to keep his employment status current at that institution. Patrick worked two additional jobs for an average total of 60 to 80 hours a week for a corporation that has two long-term acute care facilities in the state and also in rural facilities that are owned by the institution that primarily employed him. Wade worked for two traveling nurse agencies that serve the rural areas of his state of residence. Patrick referred to his second job by stating:

It's a, you know, as [name of state] is kind of backwards, we all work for money, now that always throws into the aspect of things is the money. None of us work for free. None of us can afford to work for free. And it is difficult working in [name of state] because the wages are poor here. They are the lowest, they're 10

% below the national average. The lowest of the national average, we're 10 % below that. That's what they pay the floor nurse. If you look that up in the computer, there's research to prove that but there are also things you have to look at too, there's a different set of reimbursement for the hospitals in this state. We get less than the hospitals in big cities. There's lots of different things that you have to understand too when that comes into play and I do understand that. But then, again, sometimes that's why I, you know, go the extra mile, drive to (city in the eastern portion of the state), and work three – four nights once or twice a month and get paid a substantially higher wage. (personal communication, December 10, 2008)

Wade (personal communication, November 18, 2008) stated: "I would definitely rather work in the ICU but the pay is not even comparable." Phil stated that he used to work two others jobs. One of these jobs was in a long-term acute care facility and the other was as a float nurse in two rural hospitals. Paul previously held a second job conducting autopsies with the state medical examiner. He stated that he took this job:

In part, because I was working 40 hours but I was working 24 hour shifts then I also worked, I'd work a 24 hour shift and then you'd work either a 16 or two eights so you had a couple of days off so during my spare time I got bored. (personal communication, December 13, 2008)

The history of the participants' work experiences as registered nurses was varied. Eight of the participants cited that the area of their current employment was not their first job as a registered nurse. The interviewees' work experiences included prior employment in the following areas: travel nursing, rural hospital nursing, working in an intensive care unit in another acute care facility in the state, long-term acute care, nursing home, nursing computer coordinator for an acute care facility, surgical floor, psychiatry, flex pool, heart catheterization lab, and hospice.

Four of the participants were still working their first jobs that they obtained as college graduates. Three of the nurses began their careers as graduate nurses in the areas of telemetry, the operating room, and in the intensive care unit. The nurse employed in

the area of psychiatry started as a psych tech and proceeded to work as a licensed practical nurse and then as a registered nurse in that area.

Some of the nurses advanced within their areas of employment. Three of the nurses who worked in the telemetry rotated between the positions of charge nurse and staff nurse. The nurse who was employed in the operating room was in the process of moving into an assistant administration position for that unit and the nurse who worked in psychiatry advanced from the position of psych tech to that of registered nurse. Paul (personal communication, December 13, 2008) from the operating room related:

You know, and once you find your niche, that's, if you're happy and you're satisfied with the work that you are doing and that's kind of where. I could have stayed as a staff RN in the OR. I could have stayed there. But there's advantages of going up, getting in the different aspects of the business and it's, I get along well with my coworkers and no call, no holidays, no weekends, you can't beat that. Especially if you want to be with your family today.... [M]y wife can work part time so we don't have someone else raising our kids.

Part I: Making the Big Decision: Choosing Nursing as a Career

The first part of the interviews was concerned with circumstances and influences that surrounded the decision for these participants to become registered nurses. This section contains the topics of Recruiting Efforts, The Influence of Others, Reactions of Others to the Choice of Nursing as a Career, and Reasons for the Choice.

Recruiting Efforts

Eleven of the twelve participants did not receive any information about the options for nursing as a career from a high school guidance counselor. Two of the twelve subjects said that they talked to a counselor about their plans for college. Christopher (personal communication, October 30, 2008) stated:

I had talked to my counselor gal and I was thinking about doing med school at the time and she recommended to me that maybe I should try nursing because if I

majored in pre-med I wouldn't be able to do anything with that, if I didn't get into med school.

Paul (personal communication, December 13, 2008) stated and that his high school counselor was "only concerned with one thing and that was football."

You know you always have the "What are your aspirations?" in high school, but no one ever pushed or said "This is what I think would be good for you." You took the tests here and there that told you what you were geared toward, but no nothing, no teacher or individual ever said "you would be a great nurse." (Monte, personal communication, October 27, 2008)

Monte and Adam took health careers classes in high school and were able to job shadow female nurses to fulfill requirements for those courses and both of them reported that those experiences were positive. Monte stated that his experience in the emergency room was "Very good. I definitely wanted to look at that as a profession. I loved what they did. I enjoy taking care of people and I thought that was what I had to do." (personal communication, October 27, 2008)

The Influence of Others

Eight of the interviewees had close female relatives who were nurses or worked in health care. These close relatives included mothers, sisters, aunts, a sister-in-law, and an ex-wife. Paul was influenced to become a nurse by a female college academic advisor who was a member of the nursing faculty. Phil (personal communication, November 14, 2008) related on how his sister-in-law influenced his decision to become a nurse:

Honestly, I kind of got talked into it. Not profound, I'm here to fix the world, actually my sister-in-law was going out to college to be a nurse and talked me into it otherwise I just thought it was a girl's profession. I would have never thought of it in a million years.

Patrick and his wife entered a nursing program at the same time and now have a sister-in-law and a brother-in-law who are registered nurses. Richard supported his wife to

complete her nursing degree and later went to the same institution as she did to receive his education. Nursing was also her second career. Christopher and Jonathan had younger sisters who decided to become registered nurses after they enrolled in nursing programs.

James was the only participant who did not have close personal connections to anyone who was a registered nurse. He was exposed to female nurses who worked with his elderly parents who had multiple health issues. Although he did not have a close contact to influence him, the following passage does indicate that he did receive some parental guidance:

There was just, I guess there was no, can't put a specific finger on it. I think one time my mother was in the hospital said "Why don't you become a nurse?" Because I essentially understood everything that was going on, they would tell me what was going with my parents so she said, "Why don't you become a nurse?" After a couple of riffs in teaching I thought, "Well, maybe." (personal communication, December 2, 2008)

Eleven of the twelve participants made the career choice to become nurses with no male influence on either a personal or professional basis. Wade stated that he knew of an older neighbor who was in his mid-twenties from his rural ranch who was a registered nurse. He did not have any personal contact with this nurse during the time of this career decision. Wade and Jonathan stated that they heard of at least three acquaintances from other rural schools that they competed against in high school sports who enrolled in different nursing programs after they made their career decisions. One of Wade's acquaintances was Jonathan and one of Jonathan's acquaintances was Wade.

Reactions of Others to the Choice of Nursing as a Career

Eleven of the participants stated that they received strong support regarding the choice of nursing as a career from their families especially their parents or wives if they were married. Jonathan (personal communication November 13, 2008) stated:

Everybody said, "That sounds good." No one told me not to. They said, "You go ahead and go for it," or whatever. My parents really liked the health care and they like us, me and my sister being in health care.

Monte related "Oh definitely. Aunts even to this day whenever we get together, they ask 'How are things going?'" (personal communication, October 27, 2008) William (personal communication, November 25, 2008) stated that he did receive support from his wife but did not receive support from his sisters:

But they did not encourage me. They thought, this isn't going to work out. Because knowing me being quite outdoors and they knew what I didn't know. They knew what nursing involved. And so they did not encourage me – they didn't discourage me but just rolled their eyes.

He also spoke of his parents' reaction to his decision:

My parents [paused] because they figured I should be a farmer. That is what I have always done and they thought you are going to be a nurse [paused] *you? Outdoor William?* And you are going to study at [name of a college]? It all sounded very bizarre. I know it did. I don't blame them. I don't blame them for feeling that way and some of my neighbors out there on the farm, figured he will be back in a month. I don't blame them for discouraging me. I would have done the same thing with my kid I suppose. Because it didn't look like something that would work. (personal communication, November 25, 2008)

One of the participants stated that his strongest source of support was his freshman orientation academic advisor who was a member of the nursing faculty. He stated:

My mother was an LPN so I had seen what she had done as a nurse and I looked at my options....[T]here wasn't too many, I guess, influences. Because my mom had passed away when I was in high school, my dad really, he never went to college so there was no real push there. (personal communication, December 13, 2008)

The majority of the interviewees may have received support from their families but this was not true of most of their male friends. Christopher (personal communication, October 30, 2008) stated "I would occasionally get razzed about that a little bit they would call me Gaylord Focker but they weren't discouraging me they were just razzing

me as my friends.” Jack said “I got a lot of flak from my friends, the male nurse thing, whatever, you know.” (personal communication, November 28, 2008)

The participants in this study continued to receive some stereotypical remarks about men in nursing. Richard, who was a nurse for 12.5 years at the time of his interview, shared an experience that recently occurred when he was at the bedside of his critically ill father who was dying:

Actually the thing that blew me away, I'm a male nurse, just, being in, how - this last winter, there were quite a few male nurses in [the name of a hospital in the eastern part of the state] but, he [his father who was a patient in the hospital] told me, “That guy is definitely gay.” I looked over at him and said, “My God, I'm a nurse too.” And when he said that, I mean, it surprised me. [Motioned with his hands and his face became flushed] But I don't know why he said that or I didn't even know the person but it was actually through the thing but I don't know if people feel that men in nursing are. I sure don't feel that way or see that but I'm sure some people probably feel that way. (personal communication, December 3, 2008)

Jonathan (personal communication, November 13, 2008) related:

My friends, they make fun of me. They always call me a nurse. That's why I get made fun of, professional ass wiper....[M]y friends say, “Oh, yah. Save lives, one wipe at a time.” But some of them, see, it's kind of weird like they will be so quick to make fun of you but I really don't make fun of them because, you know, because I could say, “Well, you know, you are just a laborer, you don't have an education, you are making fun of me for being educated but you are just a laborer.” I don't say stuff like that because it's kind of mean. The ones that don't make fun of me, they're kind of sitting and they're not making fun of me and then I am making fun of everybody.

Reasons for the Choice

The interviewees shared many reasons why they chose to become nurses. These reasons included: decent job, steady employment and income, indoor work, work that was not as physical as other jobs, job mobility throughout the world, opportunities for lateral transfer and advancement, the chance to work with people, the opportunity to

learn, and being able to help others. Wade (personal communication, November 18, 2008) stated one of the reasons that motivated him to become a nurse:

The reason that I chose nursing, I did have, I do have a sister that's a nurse.... [A]nd through talking with her kind of realized that there's so many options once you get into nursing. Nursing isn't just one set duty. There's so many different things you can do, so many different areas you can work in and so many specialties beyond that if you want to go back to school. You're not limited to just, you have different avenues to take. If you didn't enjoy one aspect of it you can shy away from it and find something you are comfortable doing or something you enjoy.

Richard, who had previous work experience as a hospital orderly, stated "It just seemed interesting and I've always had a sense of caring for people, I guess, or taking care of people, customer service, kind of what nursing is all about." (personal communication, December 3, 2008) William came to the interview prepared with a list of his motivations to choose nursing as a career. One of his reasons on his list was:

I thought it might be an occupation where I could exhibit the love of God. Being a Christian person, I was looking for a meaningful life. And I thought, people are sick there and people come to visit the sick. And it's a time when people need comfort and support and it's a good time where you are doing what God said to do [paused] to visit the sick and help people that are in trouble. So, I thought that would be good. I am looking for a meaningful life and nursing could be just that. (personal communication, November 25, 2008)

Six of the respondents stated that they entered the nursing profession with intentions of using their education as a stepping stone to another career. Wade cited that he chose nursing because of the "different avenues you can take, once you're done." (personal communication, November 18, 2008) Five of the twelve interviewees entered the profession with the aspirations of becoming nurse anesthetists and one thought that nursing would be a good degree to obtain to prepare him for medical school. Christopher (personal communication, October 30, 2008) stated, "Well, at the time too, we had all

been thinking that I'd be going to med school so they figured it would be a good stepping stone."

Adam, who had original intentions to go into nursing as an avenue to go to anesthesia school said:

I got a lot of comments about choosing a profession where I would be working with all women. They thought that it was kind of a woman's job. And it's like you must be going into nursing to go back to anesthesia school [lifted his hands to make quotation marks with his fingers when he said anesthesia school] because that's what all guys that go into nursing want to do. (personal communication, December 5, 2008)

Part II: Welcome to the Nursing Profession: Educational Experiences

The data that was obtained during the second phase of the interview evolved around the participants' educational experiences while enrolled in their respective nursing programs. Topics that were delineated from this section were Expectations of Nursing and Nursing Curricula, Treatment by Instructors and Classmates, General Nursing Practice Experiences, and Muddling Through Maternity.

Expectations of Nursing and Nursing Curricula

The participants reported overall satisfaction with their nursing educational experiences. All of the respondents stated that they believed that the curriculum was challenging and they expressed pride in completing what they considered a difficult curriculum. Christopher (personal communication, October 30, 2008) also stated that his parents were pleased with this level of education and shared this observation: "Yes, they [his parents] figured it was a good stepping stone and even now when we talk about it, they're glad that I do it and they're surprised, as a nurse, how much I know."

The respondents who had previous experience in health care believed that they were prepared to learn the work of nursing. Jack (personal communication, November 28, 2008) stated:

I didn't go into nursing blind, I knew what I was getting into.... [S]o it wasn't like "Oh no, this is a big surprise, more than I wanted to do." Because I kind of knew what the expectations of the job were already.

Two of the nurses did not know about the depth of knowledge or the type of work that was required of a nurse. William and Christopher entered nursing school with the expectations that they would be educated to function at the same level as nurses that they observed in clinic settings.

I thought well it would be like nursing that I saw when I got my basketball physical 25 years ago. You go in there and they take your blood pressure and they take your urine specimen and they say, "The doctor will see you soon." And I thought that sounds like a good job to me. And that is what I thought it was. And then when I started going to college and my teachers, they started teaching us about putting tubes and hoses and apparatus and suppository in all of these places. I thought "Oh my goodness." I said to one of my teachers, "I didn't come here to be a doctor. I want to be a nurse." And she said, "Oh no, no, this all goes with it." See, I thought doctors installed the IVs, the chest tubes, the nose tubes. I had no idea. And so, oh my goodness, what have I gotten myself into?....[I]f I had known I wouldn't have done it. I was ready to quit....[B]ut I didn't quit. (William, personal communication, November 25, 2008)

Christopher noted:

I guess schooling was a lot more involved and difficult than I ever had expected because I pretty much breezed through high school. I didn't know that nursing got in depth on like the pathophysiology stuff, you know. What I saw as a nurse beforehand was taking vital signs and listening to your heart and lungs, maybe, in a clinic, usually they don't it's just the vital signs so that was kind of my idea of a nurse at the time. So I never really had any idea that we got that deep in like health assessment and all of those classes. But it was a good thing too, you know, it challenged me, I always liked a little bit of a challenge too in school. (personal communication, October 30, 2008)

All of the subjects emphatically stated that they did not change their minds about switching to a different major or quitting after they enrolled in their nursing programs.

Monte's statements mirrored the sentiments expressed by the majority of the respondents:

I guess that I was strong headed, I guess I knew what I was going to do and no one was going to get in my way. It's pretty much how I am with anything. Put my head down and keep my nose to it and get it done. (personal communication, October 27, 2008)

Many of the participants stated that they thought about quitting nursing school at some time during their programs of study. The junior year was cited as the most often time because of the extra work that was required for nursing practice experiences. All of the nurses in this study did complete their programs of study and graduated at the projected dates of their class cohorts. The following statements made by Phil (personal communication, November 14, 2008) were typical of the feelings that were stated by some of the subjects.

The junior year you have a lot of the papers and there was a lot of extra homework that you didn't have the first two years. It's about the easiest way to say it. And it was just too much.... [I] stayed because I really liked it. You know, up to that point we only had two days of clinical in the hospital and I've been on the patient side but not on the other side so out of what I learned, I liked it, we started the clinicals the junior year, I started enjoying that and that's why I did it...that's why I kept on with it.

Wade, who entered the profession of nursing immediately after high school with the goal of becoming a nurse anesthetist stated, "At times when I thought that maybe nursing wasn't that great of an idea for me they [my parents and sister] kept me focused on it and just reminded me of the different avenues you can take, once you're done." (personal communication, November 18, 2008)

Jonathan (personal communication, November 13, 2008) talked about his approach to the paperwork that was required for nursing practice:

I didn't, at all, stress out like the *girls* (emphasis added) in our class did, I actually thought the majority of nursing, a lot of the majority of this stuff was quite fairly easy for me to do....[M]y stuff wasn't near as in depth as some of theirs was, like care plans and you know, the paperwork. I didn't go near too in depth.

Monte voiced the following sentiments about some of the paperwork that he was required to prepare for nursing practice as a nursing student:

You know when you're going to school ...care plans I hated them. I didn't like them. I thought they were a waste of time. It probably gave you some guidance as a new nurse, I won't deny that but to this day I hate kardexes [a form that serves as a quick reference for the needs of individual patients that is kept at the nurses' station] now I see how they are so little used or paid attention to in the profession. I just feel that kardexes, it gives you guidelines, but after being a nurse this long, I just probably know the things that I need to do better than they can tell me on the front. That is one thing that I hated in school was the stupid kardexes. I hated filling those *flippen* (emphasis added) care plans out. I still do.

Some of the respondents thought that the curriculum was not gender neutral.

I think because of the agenda, the books, the tests, NCLEX the whole thing [paused] I think is written predominately by women. And I just think, sometimes when I was writing these tests and stuff and I was trying to think, "Okay a woman wrote this, I have to take this in mind." Because I just felt like it was more meticulous and stuff that didn't interest me at all [paused] whereas if it had been a man the questions would have been more general. And so I felt I was at a disadvantage in the educational part. (William, personal communication, November 25, 2008)

Christopher (personal communication, October 30, 2008) did relate that he felt the need to talk to one of his instructors after one of his first classes in his sophomore year after viewing a video regarding professional communication:

I know during my first year of nursing up there, we watched a video and it was a video from probably the 1980s and it kind of depicted males as bringing females down and I had actually told the teacher after class that I was offended by the video and I think she should and any other male who was in that room would have been offended as well. So, I told her she should consider finding an updated video that didn't depict men coming down like physicians....[S]ometimes physicians

treated the nurses poorly but there was a lot of stuff that just kind of depicted men as holding women back forever. That was the only time.

Treatment by Instructors and Classmates

All of the respondents had at least one other male enrolled in the nursing program at the same time that they were and the average number of male classmates for this sample was five. Wade's class had eleven males in a class of forty-four. There were a total of thirty-six males and females who graduated in James' class. He stated (personal communication, December 2, 2008) that the number of males who graduated from his program were "Three out of the four, the fourth one stole the funds from the campus Student Nurses' Association and hit the road so three out of the four of us finished. [Laughed] The non-larcenist ones continued."

The respondents reported that they believed that they were treated fairly by the instructors and fellow students while they were enrolled in their nursing programs. All of the respondents were taught by faculty who was almost exclusively female. Jack stated "I don't think it was an advantage or disadvantage to be a male in the nursing program. Tell you, we all had to take the same classes, we all had to be in the same clinicals." (personal communication, November 28, 2008) The statement by Monte (personal communication, October 27, 2008) reflected the feelings of the vast majority of the respondents. "I felt no discrimination from teachers or students. [Shook his head] I got along very well with my class, all my instructors. I never felt bad or treated differently than anyone else." Christopher (personal communication, October 30, 2008) made the following statement about his beliefs about the treatment that he and his male classmates perceived about the female faculty of his nursing program:

I think they were just excited that more and more men were getting into nursing. I think they treated us fairly. I didn't even have a classmate that really said that way, "I think they're against us for being men in nursing", that just never happened up there.

One of the respondents believed that he was treated better than the female students.

However, another respondent perceived that he was threatened with expulsion from the program and manipulated by a female instructor. When he was asked why he believed he received this treatment he replied, "*What did I do?* [Spoken with emotion as tears welled in his eyes] Oh, I think I was born, at that point, really." (personal communication, December 10, 2008) He stated that he never talked to anyone before this interview regarding his concerns about the behavior of this instructor. He stated that after the passage of years he considered that incident to be a learning experience.

But, when I look back at a lot of those things sometimes, adversity is the best thing for you. Maybe it's better to have all the adversity you can have in your life because that makes you who you are. (personal communication, December 10, 2008)

One of the interviewees stated that he has not afraid to express his opinion regarding perceived differences with some of his instructors when he saw inconsistencies between theory and practice situations.

Oh, I clashed with a few instructors at the [name of the school]. No doubt about it, you can ask [name of an instructor] and a few of the other ones, [name of another instructor], was there a [name of a third instructor] out there, we didn't get along at all. Well, it was just a clash of personalities. I said being a little older, kind of knowing.... [A]nd being older, you know. With some hospital experience might have been a hindrance to you because I knew how things actually worked in a hospital, now you are being taught to do things so I really clashed there a little bit. Don't get me wrong, you need the nursing education, you need the theory, but sometimes the practice and the theory aren't the same. (Jack, personal communication, November 28, 2008)

Phil believed that the overall nursing curriculum was gender neutral and that he did not get treated any differently because he was a male:

Not that I can really think of....[T]he only time [paused] maybe little things like a big thing at the end of the year or the end of the course was like the pinning ceremony. I'm not going to wear a pin and guys are not going to wear skirts or hats. I don't want to say I felt excluded because I wouldn't feel that way but it was just little things. Some of it was still directed towards the gals. Nope. I didn't go to the pinning ceremony. (personal communication, November 14, 2008)

All of the males in the study were outnumbered by female classmates and constituted a minority in their nursing cohorts. Adam related that he was very aware that he did not fit the picture of a "traditional" nursing student. He stated "I don't want to say I felt out of place. It was obvious that I was a limited few." (personal communication, December 5, 2008) Christopher stated that "we were the few and the proud.... [I] didn't mind being in the minority.... [A]t the time, I figured, well, maybe I'll meet a wife some day. So.... [A]s a guy, they could keep me straight, they knew who I was." (personal communication, October 30, 2008) Jack (personal communication, November 28, 2008) provided the following description about his male classmates:

We had an eclectic group to say the least. Yes, we had quite the class. Like I said, we had the "class act". You know with the stigma with male nurses, you know, about being gay and all that kind of stuff. Well, we had two gay ones and one bisexual and one guy married to his first cousin. That's what I always said, "We had quite the group of guys."

Patrick (personal communication, December 10, 2008) stated that he did not care about societal stereotypes that may have been spoken about him or other males who were nurses "Why would a light-wristed guy be a nurse or something like that? But I never really had any problems other than the difficult in just making it. That was the big thing." James said "I was in my mid-thirties and my ego when it came to those things was not to be too readily bruised anymore so." (personal communication, December 2, 2008) Phil (personal communication, November 14, 2008) made these remarks:

When I first started nursing it [paused] I wasn't going to stand on a tower and yell "I'm going to be a nurse" because people would look at you funny. It's not like that anymore.... [B]ut, I can walk around with my head up high and say, "You know what, I work in a good hospital as a nurse."

James talked about the treatment that he received from his college classmates:

There were a lot of older than average students in the group so it wasn't, there were a fair number of us in our 30s and 40s in that group of 35, and probably a third of the group was at least that old. So there were a lot of older than average students who were experiencing a change in career. The rest of the population was a little curious, you know, because I went through there when I taught music as well, the old joke was there were three sexes, male, female, and music teachers so, same difference, most men who were nursing are gay or something like that you know. (personal communication, December 2, 2008)

Phil (personal communication, November 14, 2008) shared these comments that he received from some of his female classmates: "But you kind of get razzed about, 'Oh you got to put your skirt and hat on.'"

General Nursing Practice Experiences

The subjects reported that they generally had positive nursing practice experiences as nursing students except in the area of maternity. The nurses who did not have exposure to the health care system did experience some uneasiness performing personal cares and procedures on patients. Some of the participants stated that some of their patients questioned their motives for the performance of assessments or procedures.

And if you're a young doctor, anesthesiologist, nurse anesthetist, for some reason, it's okay. But as soon as you come in as a male nurse, they kind of give you that look, you know, "What are you really doing?" Because nursing is hands on. You're doing your assessments and things like that and if you're going to do proper assessments you need to do your job. So you're going to manipulate, you're going to palpate, you're going to do things like that and some of the females didn't rather appreciate that. (Paul, personal communication, December 13, 2008)

Those who had experience providing care to others found the nursing practice experiences less stressful. Richard (personal communication, December 3, 2008) stated:

“Clinicals were fun – I had some experience being in the hospital but clinicals were different aspects of different roles but clinicals went very well.”

All of the nurses took care of women and men during nursing practice experiences. All of the participants never had a refusal for them to perform cares from a male patient but sometimes women did refuse to let them provide care to them. Wade’s statement reflected circumstances that occurred to all of the participants. “They were okay with it until I needed to give them a bed bath or something and then they would be leery about it and request that I ask a female to help them, but not regularly it has happened.” (personal communication, November 18, 2008)

All of the interviewees completed nursing practice experiences that were required for their programs of study. Many of the respondents favored some of the nursing practice areas over others and wished that they could have had more concentrated time in their areas of interest. Adam illustrated this aspiration with this statement: “It would have been nice, when you do your clinicals, to pick which ones you’d like to have more time compared to others.” (personal communication, December 5, 2008)

Paul was the only participant who reported an incident during a nursing student practice in which a patient questioned his sexuality:

I was a student nurse.... [A] male patient, I was taking care of this patient on [name of a hospital unit], old guy, yes surgical, chest tubes in, I was taking care of him. I said, “I’m a student nurse.” He asked “You’re a male nurse? Are you gay? Do I need to worry about you?” Absolutely I had that more than once. Oh yeah. Older generation. Absolutely.... [I]t’s the boomers. Boomers and above.... [I] had to think. I told him, I said “Nursing is not strictly female profession, it’s a medical profession.” It’s the one I chose. What my orientation was, is none of their business. I said, “I’m not gay but what my orientation is, is none of your business.” (personal communication, December 13, 2008)

Muddling Through Maternity

The interviewees overwhelming reported that the area of nursing practice that was the most difficult for all of them were experiences in the area of maternity. Christopher's perspectives of his experiences in this area were echoed by all of the respondents: "It's just kind of an uncomfortable situation but I understand it's tough for the nursing professors too, they shouldn't really have to cater to us but I don't know how that could be made better." (personal communication, October 30, 2008) Monte's statements matched the feelings of the majority of the respondents regarding their maternity nursing practice experiences:

I guess I could generalize that us males were uncomfortable with those classes. Didn't mind learning it, didn't mind doing it, but to actually have to, I knew it was an area I wasn't specializing in when I was done. (personal communication, October 27, 2008)

It was also hard. Being a male in nursing in the mom-baby setting was real tough. Being a young guy, you work with, work with the females and you're doing breast exams and you got that, you're doing episiotomy checks and things like that. You know even though it's very professional, but you always have those mothers that kind of give you that look like, "Boy, what are you really doing here?" That type of thing, again. It's that stigma. I put that in quotation marks. "A man on a woman's floor." Especially at [name of a hospital] on the women's floor, is all women. Women's surgery is female dominated and orientated [sic], female surgeries are done upstairs, it's in a separate unit, have their own part of it as labor and delivery has. I don't believe they have male nurses. Mom-baby does not. Women's surgery does not. It's difficult going in as male and then as a young male. (Paul, personal communication, December 13, 2008)

James stated that "The curriculum was gender centric, the expectation was that you need to pass OB/GYN [obstetrics/gynecology], but we'll be damned if you are getting anywhere near any of *those* people [female patients in those clinical areas]." (personal communication, December 2, 2008) Richard's statements illustrated James's comment: "The OB end was probably better because we got out of some work because with the

female thing they – female nurses took care of that aspect.” (personal communication, December 3, 2008) Jonathan’s narration of his maternity experience strongly supported James’s and Richard’s statements:

I really didn't notice much difference except for going through, like, labor and delivery was kind of, not a very interesting thing because you don't really get a lot of opportunity. Well, I didn't, I don't know if the other guys did, but I didn't get in on anything. I just kind of stood around and said “Blah, blah....” [I] got to do the infant stuff, but nothing really in delivery. (personal communication, November 13, 2008)

Phil (personal communication, November 14, 2008) emphatically stated:

We muddled through. Like when you got on the floor and did the clinicals – we had a female with us whenever we went in to do an assessment or something. And I knew I would never work there. So I did just enough to muddle through – we just muddled through.

Some of the nursing students needed to find their own patients and obtain consent from them without the help of their instructors. William went through maternity experiences in two nursing programs and during one of his experiences he needed to find a mother who was about to give birth to consent to have him watch the delivery. He described his experiences:

In Labor and Delivery.... [I] didn't want any part of that, needless to say. And I felt very awkward.... [I]t was my job to go to room to room and find a woman who would let me watch her delivery....[I]t took about four or five rooms – and I almost said, “You don't want me to watch do you?” “No I don't, get out of here.” Finally, at the fifth one she said, “Come on in.” Much to my chagrin. “What does it matter?” And she grinned. But I didn't like that at all....[A]nd I actually sat in on two of them where I held the leg...[B]ut the women were, like, “so what.” But there were four of them that said, “No.” And I don't blame them a bit.... [L]ater on when we did “mom and baby” [rotation] it was the same way. It was awkward – and I think one time a patient said, after the first day said “I don't want any student tomorrow.” It was awkward – sometimes when it is women’s issues with episiotomies it’s awkward it's no place for men. When I went to my baccalaureate program, here we go again, got to do Labor and Delivery again. So I said a prayer, you had to do two 12 hour shifts, during that 24 hours not one baby was born. I sat there for 24 hours and did nothing. And when I left they said “This has never happened do you want to come back if we get one – should we

call you at home?" I said, "Nope! Don't bother, I am totally happy with the way it went." They said it had never happened in 24 hours. (personal communication, November 25, 2008)

Some of the nurses needed to find mothers early in their pregnancies so that the students could participate in prenatal care as well as witnessing the birth. Phil related that when he received this class assignment he was at a loss as to how to find this expectant mother.

The only one that was really, really hard was the rotation on mom/baby. I remember the assignment was we were supposed to go out and find somebody pregnant. What would you do if you had a guy walk up to you, in the mall and say, "Hey, I see you are pregnant, can I help with it?" (personal communication, November 14, 2008)

Some of the respondents witnessed cesarean section births. Christopher (personal communication, October 30, 2008) stated:

Luckily it was a C-Section. So I was a lot more comfortable with that. They tried to give us the older ladies. They didn't want us with somebody who was 21 to 22 years old and I think most of the men in my class saw someone probably 37 and older.... [F]rom class they showed us how to check a fundus but they primarily during my OB rotation, we did just vital signs and lungs and heart and the nurse or professor would do the fundus checks, she agreed to do that so. They tried to keep it as comfortable as possible.

Some of the respondents did not witness a birth as a nursing student.

Clinicals. The only real trouble I had with clinicals, not real trouble even, was the mom/baby rotation. It was just very uncomfortable for me. We were supposed to watch someone, an actual birth. It just never worked out. The person I had [been assigned to] I was gone when she delivered, and tried a few other ones. Very uncomfortable. I did actually graduate without having to see one. I figured I saw it out in the pasture enough times, I didn't see it for real. (Monte, personal communication, October 27, 2008)

James (personal communication, December 2, 2008) described an incident where he was displaced by female nurses after finding and reporting a complication to his nursing instructor that was occurring to his patient shortly after giving birth.

Yes, one time, there I was, I was assigned a lady and she was fine with me taking care of her, she had just delivered and we were getting along fine, her fundus was

a little boggy so I was massaging her fundus a little, the next thing I knew I found myself standing out in the hallway with nothing to do for the next hour and a half. So which is kind of, ticked me off, big time. Let's adhere to it, if you have certain expectations of all of us and provide us the same opportunities. Well the instructor got this glazed look in her eyes and the next thing I know I had nothing to do for. So it was like, okay, *whatever*.

Christopher (personal communication, October 30, 2008) told the following narrative about his maternity experience:

I can't say I felt terribly comfortable in my OB and stuff and we had to teach breast feeding whether I was a guy or not, everybody in the class had to teach breast feeding. So I had a 40 year old mom and I walked in and I told her I was going to teach her breast feeding and she looked at me and I looked at her and we were both thinking, "*What the hell does he know about breast feeding?*"

Other participants were also required to teach breastfeeding to satisfy maternity nursing practice experiences. Phil (personal communication, November 14, 2008) shared his experiences teaching breastfeeding to a new mother:

How am I going to teach somebody how to breast feed? It is *not* going to happen....[W]e had to go through it...we had to have somebody listening and we had the instructor there and we had to teach that stuff and – and the patient is laughing and I'm laughing and the instructor starts laughing. It was uncomfortable but it happened.... [I] knew I would never work there. I wouldn't even apply.

Jack (personal communication, November 14, 2008) addressed that he always had a woman present in the room with him to perform assessments on the postpartum unit. "The mom-baby rotation I had to go to but you always had a female nurse with you to do any kind of exam like checking the fundus thing or whatever."

Most of the men made statements that they basically got through the maternity nursing practice experiences as students and that they did not view this as an area of prospective employment as registered nurses. Patrick stated: "I don't think, are there guys that work on the birthing center? I don't think there is, probably never will be unless you want to get sued." (personal communication, November 14, 2008) Monte's statement

summarized the feelings of the majority of the participants regarding the maternity experience: "But it's just uncomfortable when you have, young moms and young dads, and you're doing what you do. There are some areas that are best left to women."
(personal communication, October 27, 2008)

Phil shared that nurses who work in rural hospitals were not immune from maternity situations. He previously worked as a charge nurse in a rural hospital and faced his first delivery alone:

The charge nurse took care of OB. So we had a rule that if somebody came in I [the charge nurse] would have to hook up the monitors – get them set and then I would call the OB nurse that was on call. And only once was it a close call. I was in ER and a gal came in passing through going from [a city] to [a city] and went into labor and it was like here is an emergency room on the way. So I got on the phone, and it was *an old* OB nurse. I called her and told her about it and she said "Well, they can't do that." And I said "Get your [blank] in here" and she did. I told the patient to cross her legs a little bit longer [smiled]. (personal communication, November 14, 2008)

Part III: In The Trenches: Work Experiences

The third part of the interviews dealt with the participants' work experiences. The areas of The Work of the Nurse, The Clustering of Men: Their Stories, You're A Nurse? Patient Reactions, Below the Belt, Spinning Wheels: Geriatrics and Chronicity, Working with Women, The Thin Line, Advantages of Men in the Profession, Personal Communication and Socialization with Coworkers, Committee Work, Communication with Patients, and Communication with Physicians were delineated from this portion of the interviews.

The Work of the Nurse

All of the research participants have worked full time in various roles as registered nurses since graduation from college. Adam (personal communication,

December 5, 2008) made the following observation about the work of a nurse. "It's very grueling work which I found, I thought it would have been easier than it actually was but I was very wrong." Patrick related why he believed that the work involved in the nursing was hard. "I think you have to work harder than most other fields because you have to put up with physical, emotional and spiritual stress, you have all these stressors on you."

(personal communication, December 10, 2008)

You're kind of the eyes and ears for the doctor. I think, sometimes, I even do more than the doctors except you can't write orders. This the same way everywhere because that nurse in ICU is the one that's seeing the heart rates or seeing the different heart rhythms and they are able to get make that first call on that patient if they are starting to take a dive. It's the nurse. (Paul, personal communication, December 13, 2008)

Jonathan addressed the responsibilities of the nurse in the following narrative:

You have to be watching everything they [physicians] do so you got to know almost as much as them and follow their orders. Because if you mess up, *it's most likely your fault anyway*. I don't know, it's just that you got so much responsibility as a nurse and you have about the same responsibility as a doctor, you have more patients....[Y]ou have so much responsibility and your really not even that high up on the totem pole, know what I mean. I guess you can move up and be like a nurse practitioner, PA [physician assistant] or something like that, move up. But if you stay as a four year nurse you got so much responsibility on just that four year degree on you. I think a nurse is underpaid for what their responsibilities that they have and they carry out all the orders and they carry out all the patient care and....[I] think you're underpaid for the responsibility and tasks that you have, really. (personal communication, November 13, 2008)

Christopher expressed his thoughts about the work of the nurse:

I didn't know that you actually had to be the one to push these people. You think everybody has the drive, like when we have an open heart patient, they got to get up and walk, they have to use the inspiratory hold [a device to prevent respiratory complications] and when they're in pain you hate to make them do it and if you don't, they get pneumonia or something along that line so that's something I didn't know nurses did either that you actually push these patients that they didn't want to do it for themselves. (personal communication, October 30, 2008)

The Clustering of Men: Their Stories

Ten of the interviewees worked in the areas of telemetry, intensive care, dialysis, emergency rooms, and the operating room that required high technical and/or critical care skills. The remaining two nurses worked in psychiatry and in a flex pool that involved transitional care, rehabilitation, psychiatry, and medical/oncology units. Phil who worked in the critical care area of telemetry readily gave the following explanation regarding the clustering of men in certain areas of the hospital:

Now on the other side, your hospice, oncology and medical floors you need to have more of a caring, more doodling on them and whatever, you have to have more of a caring attitude.... [W]e have talked about that amongst ourselves [Monte, Christopher, and Phil] and we all feel that way. All of us would rather have super critical patients...than one we have to go and wash their mouth and feed them. And I think the reason is we want to see them get better and a lot of the *girls* (emphasis added) on the floor they care about: "*Why aren't his toe nails clipped?*" And this needs to be done. And we look at - *he just had a heart attack and bypass and we need to take care of this*. And I think that is why the oncology floor has more female nurses than male nurses. I know a lot of them on the floor and there are two males up in psych, and then they have three of them that are in the flex pool which would be in that medical/ surgical or medical/psych area. But otherwise all the rest of the males are working in ICU, tele, or ER or flex pool. (personal communication, November 14, 2008)

The nurses who were employed in the areas of critical care, the emergency room, and the operating room described the exhilaration that they experienced when they worked with patients who were in unstable condition. Jonathan explained his beliefs why the majority of men work in these areas: "Men like to work with acute care stuff, like the ERs, ICUs, telemetry, because that's where the excitement is. I think a lot of guys need more excitement." (personal communication, November 13, 2008) Jack who worked in the emergency room shared "After a while, there's some things in floor nursing you can just do in your sleep, some aspects of it." (personal communication, November 28, 2008) Patrick stated reasons why he enjoyed his present job in the emergency room:

What I like about ER is I do like the critical care. I like when things go bad. [folded his arms] I am not afraid to run a code or defibrillate somebody – I do it all the time. And that is what I like about being in charge...and then when something that comes in that is good, I get to go and either run it or work with the physician who is running it.... [W]hen someone hands you a baby over the counter and it's coding....[I] had people run in and throw a baby over the counter to me, it's coding, you know, and do CPR on the baby right away.... [I] tell when somebody is really sick. Like I went out to the car the other day to get this lady out of the car and I opened car door and said "She is going to be dead in a couple of seconds here." I could just tell with one look at her and I knew she was dying. And I got her right pass the registration desk and she went into ventricle fibrillation and was out. And I just grabbed her by the shirt and pants and swung her up in the air slapped in the bed and shocked her – ended up shocking her seven times and took her down to the heart catheterization lab and shocked her another seven times in the heart catheterization lab and she went home....[I]'d rather have the excitement. (personal communication, December 10, 2008)

Paul's experiences in the operating room paralleled those of the critical care and emergency departments: "The adrenaline, absolutely, adrenaline junky. Those emergency cases. You have a motor vehicle accident. The feeling you get after working for hours on somebody, knowing that you made a difference." (personal communication, December 13, 2008)

Phil (personal communication, November 14, 2008) stated:

It's like telemetry most people don't like that but that's just enough chaos to where I like it, you know, adrenaline or whatever, you know, it's just hard enough patients to keep you busy all the time but you get to see the patients get better. I like that.

Experience in intensive care is a prerequisite for anesthesia school. Wade was the only respondent of the twelve nurses who still had aspirations of possibly becoming a nurse anesthetist at the time of the interviewees. He spoke the following statements about his interest in the work of the intensive care setting:

The ICU was kind of where I always knew where I wanted to work. I mean, I knew I needed that experience if I wanted to go back to school, it's a requirement but even that aside, if I wouldn't, if I totally forgot about my plans to go back to school some day, I wouldn't want to work anywhere else except the ICU. It's

boring ninety-nine percent of the time but it's the one percent of the time when something serious is going on and you got to, everybody's mind is going and you got to use everything you've got to make decisions and make them quick and make sure you're doing the right thing. So, I mean, that keeps you going, that's enough rush to keep you going through the ninety-nine percent where it's boring. Another thing is in the ICU we see a lot of bad things but we see a lot of incredible things that happen. (personal communication, November 18, 2008)

The requirement of critical care experience prior to acceptance into anesthesia school can be detrimental to intensive care units because of high staff turnover and the lack of ownership by the nurses who transition through that area to the unit or to the team members who work there on a long term basis. Adam, who worked in intensive care for 7.5 years made this statement at the end of his interview that illustrated this point:

I mean, I mean it's nice to have more men around too. Usually when you see guys coming into the ICU, one of the first questions you ask is "What are your intentions? Going back to school?" It seems like more guys want to go back, they want to continue on, further their education, like anesthesia or NP or something. (personal communication, December 5, 2008)

Working with a variety of patients was appealing to many of the participants.

Adam stated:

Routines are going to change more so often like in critical care than they are just working on an ortho ward or a medical floor, in my mind. I knew right away I didn't want to work in a nursing home. And I think most men are the risk takers, they like the excitement, some don't but some are content working on the ortho floors or something.... [A]nd you know talk about the excitement that I've experienced with the codes...I wanted to do something that was more high-paced, constant learning, something you are going to learn every day. (personal communication, December 5, 2008)

Jack (personal communication, November 28, 2008) addressed why he chose to work in the emergency room setting:

So I knew a lot of the areas where I wanted to work and seeing the floors, ER was most suited for me, just because I liked the more - not more intense - but I liked the difference, it was wide variety that we were seeing...and it was the factor that you weren't taking care of the same patient day after day, eight hours at a time. It

was a couple hours at the most and if they had to be admitted, you took them upstairs and they were somebody else's patient. It was very appealing to me.

Paul cited the following reasons why he enjoyed working in his specialty area:

But I think, being in an operating room, the whole surgical experience is what I want. I don't think I could do the clinic. Too much interaction. We do have interaction with patients. But I like the, you know, we come in, we help them, we make them feel safe and make them feel good and all of a sudden, they're gone[received anesthesia]. (personal communication, December 13, 2008)

The smaller nurse/patient ratio in the high technical and critical care areas was appealing to many of the respondents. Wade (personal communication, November 18, 2008) gave the following illustration:

We have two patients and you can think, you can actually think about what's going on, you get out on the floor and you have six patients, it's pretty tough to put everything together on every patient. I don't think you can, with a workload like that, I don't think that you can provide the amount of care that somebody needs or is entitled to. It's two patients in the ICU is just as much work as six on the floor but you can keep things straight, you're not running in circles trying to remember what you were doing.

William and Richard did not work in areas of high technology or critical care at the time of the interviews.

But I found – or psych nursing found me, which I like. But, if not for that, but for the grace of God, finding that niche – I would have definitely have quit – I would not have even become an LPN. Because I do not like medical nursing at all. (William, personal communication, November 25, 2008)

Richard (personal communication, December 3, 2008) cited advantages for working in his flex pool area. "A lot of my areas are longer term and elderly. You get to know them probably a little more in – probably have a closer bond with their family and the patient themselves. Because they are there longer."

William also shared the following story about how he became employed in the area of psychiatry after he applied for an aide position at the hospital when he was a student in the LPN program:

She interviewed me and they were interested because they were thinking LPN – cheap labor....[S]he says, “I see you are applying for this aide position. Why?” I said, “I don’t like nursing at all so far.” Well she said, “Do you like nursing?” And I said, “Not at all.” She said, “Why are you here?” And I said, “Well I thought if I don’t like being an aide anymore then I like being a student nurse, I quit.” Which is nothing to say for getting a job, but I didn’t really care. I was almost hoping that she would send me home because I didn’t like it. Then she said, she smiled, and she looked at me and said, “What are you good at?” I said, “Breaking horses.” And she smiled at me and I smiled at her and she said, “I think I will send you to psychiatry.” And, I thought, “What is that?” But, I said, “Okay.” I didn’t have any idea what it was. And I went up there and I was hardly there more than a couple of days and I said, “Oh this is it.” I was 43 or 44 years old – I had been through a variety of trouble in my life – stuff with relationships and the family – you know stuff that people go through until they are 44. And I saw all these people coming in depressed and anxious and all kinds of interesting other stuff too and I thought – “Oh I love this.” Because most of my life – even since the third grade – I read nothing but autobiography after autobiography [pointed to various books in the room] and I was always interested in people and what makes them tick. And here – that’s what I had, people to talk to – tell me their stories and it was very interesting and so I thought, “This is it.” And then I was inspired to stay and get my degree. But otherwise I would have certainly quit. But, I got that job as an aide and I thought “Okay if I get my LPN they will hire me here.” Which they did. Then when I got my RN they updated me again. And I felt it was an act of God. (personal communication, November 25, 2008)

You’re a Nurse? Patient Reactions

The nurses in the study responded that reception by the patients was generally positive but that societal stereotypes still prevailed at times. Wade (personal communication, November 18, 2008) related:

Some people will question you over and over again. “You’re really the nurse?” “Why did you want to be a nurse?” “Are you good?” And then it’s “Oh, are you going to be a doctor?” It just happened to me today just before I left. Some kids asked their mother if I was the doctor and didn’t believe her that I was the nurse.... [A]nd in the rural setting the patients that are there know the nurses, they know the nursing staff and so they know that they are all female nurses so then I show up and walk into the room and it’s tough for them to understand that I’m

there as a nurse and I'll be doing that role for the shift. They maybe think that I'm higher up than that and am just doing it because they are short on staff or something like that.

Richard stated "Many of the patients will call us doctors as we walk into the room, just for gender and I eat that up." (personal communication, December 3, 2008) Jack cited the following examples of encounters experienced in his work setting:

Let's face it, there's always that stigma of homosexuality, the gay thing with male nurses, I can count the numbers of times I have been called a gay or a faggot by a drunk person in the middle of the night working in ER. Yeah, so, there's always that, the "nurse" or whatever they call them. (personal communication, November 28, 2008)

William (personal communication, November 25, 2008) stated that he sometimes hears comments from male adolescent patients in the psychiatric area:

Oh, you are a "nursie" are you? I just have to laugh....[I] will just come back with something funny and I will say, "Oh were you expecting me to say, 'How are we today?'" [spoken in a high feminine voice and flared his hands] And I say, "No take your medication or I will force them down your throat." [Spoken in a deep masculine voice and crossed his arms] I will say "I am not a feminine nurse [paused] got it?" And then they will just laugh and it is all good. No one has ever been serious that I can think of.

Wade gave the following account of his professional experiences:

When I made the decision to go into nursing and as I was going through school, I thought that I would be more discriminated against than I was. I thought it would happen more frequently and it really basically doesn't happen. At least not verbally or in actions towards me. Maybe some people are thinking it but they don't show it. So I am pleased with how I've been accepted.... [T]he people that I now work with are very, as far as I am concerned, very accepting of males in nursing. It may be because of where I work, in the ICU, they are used to us being there. There are a lot of us in the ICU here in [name of a city], it's probably over a quarter of our staff. (personal communication, November 18, 2008)

Phil's first job was in a rural setting. He talked about his acceptance as a nurse by that population:

In as far as the patients in a smaller areas, when I – because their charge nurse covers the emergency room and when I came into the emergency room they were

okay with a guy as a nurse, taking care of them. When they get to the floor, when they were admitted they weren't okay with it anymore. It was almost like they – like you are kind of a doctor because you are down here – and if they thought you were the doctor they would let you do anything – especially the ones from the nursing home and stuff – they were a little confused. As so as they found out you were a nurse they would request a female. And that happened a lot up there.... [B]ut it happened and after awhile they got to know who I was though [paused] and the frequent flyers [paused] they didn't care. (personal communication, November 14, 2008)

Christopher (personal communication, October 30, 2008) related the following about his acceptance by patients:

There's a lot of patients now, that really surprised me, even some women, they said, they are more comfortable having a male nurse. I had a guy I took care of twenty-six times, he was in for almost two months and he requested a male nurse all the time. Yes, I've had either male or female request us or say that they've actually have enjoyed having the male nurse better than the female nurse most of the times. We get our share of modest women too. I've had people say they would prefer not to have a male nurse which when I hear that, I understand. But what's tough for me is that their doctors are males so I have a tough time with that, but I'm offended to a certain extent. I shouldn't be. But I don't understand their logic. But if they prefer to have a female, so be it, I'm fine with that.

Christopher also related this personal story about his future brother-in-law who was also a registered nurse:

Well the guy that she's [his sister] engaged to, a friend called him from [name of a city in the eastern part of the state] and he was saying "My future brother-in-law is a nurse too." And then she said, "Well, is he gay?" He said, "No, actually him and he's got a few buddies at work and none of them are." I got a lot of that, that people think that if you're in a feminine type profession. Whether it be a male nurse, a make-up artist or something like that they consider that you might be homosexual, just because you have feelings. And so many people equate the two of those together. If you have a soft heart and doing something like that. I'm trying to think if I remember seeing any other, just the *Meet the Parents*, that's the only other show that I have actually seen a male nurse. I think there may be a male nurse in *ER* too. I can't remember if he is or not but I think that's the biggest thing is they think you might be homosexual because she said that most of the male nurses who are moving to [name of a city in the eastern part of the state] are, is what the gal had said.... [S]he's a nurse...this friend of his just had noticed that about the men there. I don't know, it doesn't shake me much, if you are comfortable with who you are. It doesn't bother me. I really don't care how they depict us, I get a chuckle when people crack jokes about it. Just like the gay male

nurse thing but I just laugh about it because I enjoy it and I really don't care what people say. *They're darn lucky to have us there* because, where it takes for one of us to lift, it would take two to three gals to lift the same amount of weight. (personal communication, October 30, 2008)

Below the Belt

Some of the respondents stated that they did not want to be involved in patient situations that involved female anatomy or gynecological problems. Jack stated: "I mean, like I said I don't get involved with any of the 'girly' problems. Anything bleeding 'below your belt' [made quotation marks with his fingers], you're not going to see me in your room." (personal communication, November 28, 2008)

Generally I didn't have any issues in providing personal cares, unless there was something, in some cases in the perineal nature but again that was more dealing with age wise.... [I]t varied. Some people's level of comfort or discomfort, varied by age, sometimes it was just my discomfort but I don't 'want to know anything about that, I don't want to see. No. No. I would refer to a female if I was really uncomfortable about it, yes I would or if at minimum, bring somebody with me because I was tuned into the idea of being accused of doing something inappropriate. So when it came to that type of things, generally I would bring somebody along so it wasn't that "He did that kind of thing." (James, personal communication, December 2, 2008)

Richard who worked the flex pool shared his experiences with providing care to female patients: "I provide perineal cares on women with their approval." (personal communication, December 3, 2008)

Since we do our baths at night, I'm taking care of female, say 'I'm going to do your bath here, if you don't mind, I'll be your nurse but if it's perfectly okay, I can get a female in here. You have that option.' The same goes with male patients sometimes they don't want a female nurse. (Adam, personal communication, December 5, 2008)

Phil did not always have "female backup" for situations that were below the belt when he worked in the rural hospital setting.

But you don't have to do a lot of stuff that would make you real embarrassed... like female cath....[G]uys don't do them in a big hospital. I haven't started one in

eight years at [the name of a hospital]. In [the name of a rural hospital] we had to because we were the only ones there. But, here we don't have to. (personal communication, November 14, 2008)

Monte (personal communication, October 27, 2008) stated:

There are a lot more male nurses on "tele" than other units. That's the one comment I get, "I can't believe how many male nurses are up here." But they are very accepting. Once in a blue moon you get a little old lady who is uncomfortable with a male to do certain things, you know, helping them go to the bathroom, helping them clean up, what not. You just find one of the ladies and they help you out in that area. It works out just fine. Again, it's just a few, I think there was only once and she didn't refuse, but she was very uncomfortable, so and she was an older gal and didn't want that and just took us a couple of seconds and we had things alternated around and life was good. I didn't want to be uncomfortable and surely didn't want to make her uncomfortable so we got things taken care of. She was about 80, 85. She just didn't like the idea. I could sense she was uncomfortable and said "Would you rather have a lady?" "Yes, very much." Got that taken care of.

Spinning Wheels: Geriatrics and Chronicity

Many of the interviewees also stated that they did not like to work with patients who were not going to improve and those who needed routine nursing care. Working with patients who were geriatric and people who experienced chronic conditions with no hope of a cure were cited as situations as difficult for these nurses to face as professionals. William's statements supported this assertion:

A bad day is I am probably working the adult side – I am probably taking care of somebody with dementia. And it is just totally – the guy is just pooping all over the place. And he doesn't understand anything and so he is upset and agitated and the family is upset and agitated. Or it could be a person with a head injury or schizophrenia. [Shakes his head] And no matter what you do you are not going to please these people and it is just an exercise in futility of trying to get to – to get it right. I do not like to work with people who just can't get better. [Shook his head].... [I] don't like that. But people who just can not grasp it [shook his head] because of their mental capacity and then it's just like, man I am spinning my wheels. (personal communication, November 25, 2008)

Jack stated that a bad day consisted of [Sighs] "Seven ninety-four year old patients lined up out in the hall." (personal communication, November 28, 2008)

I knew right away I didn't want to work in a nursing home.... [J]ust, seems like there's more just passing pills and just not up tempo enough for me. Although the pay is better.... [I]'d say the nursing home was the hardest for me to do. It seemed like time stood still. (Adam, personal communication, December 5, 2008)

James, who worked in the dialysis setting, stated a difference regarding his view of geriatrics from the other nurses when he described his ideal job and why he quit working with this population of patients:

I enjoyed rehab nursing and working the transitional care setting. Yes, that's what I originally did when I first become a nurse. I worked in long term care that was my first experience. I enjoyed that. You know all these people, for the most part they are mostly very nice souls and they just need some help and I had these people who were kind of demented we had to do their activities of daily living and they would try to break your fingers, smack you and stuff but they were the exceptions. Long as you knew what was going to happen.... [I] was working the flex pool, going back and forth between nights and days and physically I was so messed up. I was a physical disaster I was just shot. (personal communication, December 2, 2008)

Working with Women

All of the respondents worked in areas that were dominated by women. The nurses in this study gave varied perspectives about working with women. Patrick stated "They [nurses] are so hard on each other. And I don't understand why....[I]t is terrible." (personal communication, December 10, 2009)

Christopher shared that:

I went from working with all men to working with all women so I think that was the toughest thing in nursing with me is that men are on a more even keel than women, they don't have the hormone changes and so when I think about being miserable doing nursing, it's more or less that I was used to working with all men.... [I] needed to be in a job where I work with people even though women are sometimes difficult to work with.... [I] really enjoy my coworkers but there's a lot of stabbing behind the back and a lot of malicious behavior toward certain people and I just didn't see that at the plant. People [men] just weren't like that. (personal communication, October 30, 2008)

Paul, who worked in the operating room stated:

I've seen disputes between two females. Boy oh boy, that gets nasty sometimes. I mean, it's a yelling match...they want to be fully in control and when there's no one who is going to win...they actually hold a grudge. (personal communication, December 13, 2008)

Female nurses sometimes made isolated societal stereotyped remarks to some of the respondents. Richard (personal communication, December 3, 2008) shared "You'll hear some remarks about men. We can lift more, for women they think they can work faster or smarter or something like that but those are just wife's tales." Jonathan who was the only male who worked in a rural facility in his previous job received comments about his sex. "I don't ever think of it that I'm a guy. Kind of joke around about it a little bit, like putting 'testosterone in this place' or you know." (personal communication, November 13, 2008)

Phil shared current experiences about a female coworker who openly continually made remarks about coworkers in the work setting:

But we have one nurse on the floor right now – I don't know what her hang up is with guys and girls....[B]ut she really – she throws little digs and you just ignore them. That is the only way to deal with her. But she will throw little digs – with assignments if there is a certain patient, "Oh a guy will do better with that." or "Give it to the guys because he will do this or whatever." Just little silly things. (personal communication, November 14, 2008)

The Thin Line

The majority of the participants in the study addressed an attitude of caution and wariness that they assumed while at work. This attitude was perceived to protect them from getting involved in the gossip and conflict situations that commonly occurred in the workplace. The attitude of caution also was perceived to be used as a means of defense to

avoid possible accusations of sexual harassment against them if they are in a vicinity of a conversation that involved personal and/or sexually explicit content.

It's the thin line you walk on when you work with a bunch of women, let's be honest. There are a lot of personalities. They don't all get along with themselves very well, most of the time. I think it is in general...it is harder to work with a bunch of women than it is with a bunch of men. Jealousies, cattiness, whatever it is, there's just personality differences, whatever. I spend a lot of my time with my eyes and ears open and my mouth shut. That's my philosophy [Stated in a knowingly fashion]. (Jack, personal communication, November 28, 2008)

Patrick related "You have to know your boundaries with those *girls* [emphasis added] when you are a male, because you will get burnt. You have to know your boundaries." (personal communication, December 10, 2008)

Some of the participants who did not work with other men took lunch and coffee breaks with female coworkers. Those participants reported that at times they were not invited into the conversation even though they were physically sitting at the table with their female colleagues.

Some women beat each other up. There are little gossip sessions, I mean, you actually have to be very careful with that, I mean, a lot of times I'm the only male there in a group of eight women around the lunch table so you got to be very careful with sexuality and all that as you are talking, if you're not invited into that conversation they could be offended if you say something. But because we are definitely a minority there.... [S]ometimes it shouldn't be things that should be discussed at the table but it does happen quite often, so you need to watch what they are saying. Well, you have to be careful, I mean, any kind of harassment, sometimes you get to breaks and it gets detailed in certain things and you just need to be careful of what you would respond back if they would become offended....[A]nd you hear it a lot too from men, in the OR. Oh yes, they are probably talking inappropriately there and even with doctors and nurses in communication and you need to be careful on how you respond to that. (Richard, personal communication, December 3, 2008)

Patrick related his practices regarding communication with coworkers:

I am very careful what I say though. Because I don't have a deep trust for too many people. I learned early on not to trust people, because I got stung a few

times. Things that I have said to people have been said back to me and gotten me into deep trouble. Now if it is hurtful or something that is malice I usually don't say it. I just keep it to myself. Because something like that will get out and then you have got problems on your hands. (personal communication, December 10, 2008)

Some of the participants admitted to partaking in some gossip with trusted coworkers. Paul stated that his belief about gossip: "I think that's just human nature." (personal communication, December 13, 2008) Adam related the following: "Oh yeah, gossip is always going there.... [M]aybe a little bit less gossip but I think us guys tend to get caught up in it too. [laughed and winked] (personal communication, December 5, 2008)

Jonathan voiced his practices regarding workplace gossip sessions.

I really don't have any interest in someone else's stuff besides my own....[S]o I try to avoid situations like that. I don't know if guys would do it. I've never really been with a group of guys that have talked about somebody else – we've got better things to talk about instead of what she is doing over there. I don't really talk about work – I don't talk about work outside of work because it is really not fun anyway. Because you can't talk about patients but I don't talk about the coworkers at work because – *except for the ones that piss me off* or something but when they are talking about me to everyone else. (personal communication, November 13, 2008)

Gossip and conflicts were reported to occur at all levels of work in the nursing institutions. James (personal communication, December 2, 2008) related some of his experiences of being treated differently by female coworkers because he was a man:

Oh, several times. Yes. There were several times I thought "What in the hell am I doing this for?" I always came back with somebody was having problems with the male spouse who was, you're the local battering ram for the passive/aggressive to deal with it at home. Made my life hell for things I had nothing to do with. There was this one lady in particular, she was angry with the world and angry with men specifically and there were several times I had to deal with her. I'd had enough. And even the manager that I had to work for, wrote me up one time for being late for work. I was sitting in her office having my job evaluation and she wrote me up for being late for work. Gender becomes an issue if there's, frequently in their personal lives there are problems. You happen to be the

recipient of how they feel when they are at work because it's safe there because [paused] you're not going to retaliate against them as opposed to what may or may not occur at home.

Christopher stated:

I know there nurses who do it, I know there's a couple down in ER, they are called "man haters" but I don't think it has anything to do with, it's probably a personal thing, they maybe have gone through a divorce or something like that, it's not they hate male nurses. I think that's one of the advantages of being a guy and not having PMS or any of that stuff is that most of the time I'm on an even keel. (personal communication, October 30, 2008)

Two of the nurses had their first jobs in rural hospitals. Phil had two female cousins who worked in the facility where he first was employed:

They said that there were two males that worked there before me. Both of them in their words were run out and they didn't like them....[T]hey kind of rode them a little harder and gave them harder assignments and when I went up there I kind of knew what to expect a little bit. So when they would say stupid stuff or you know a lot of it was sexist – they would say like, "Now that the men are breaking into our area" – that kind of thing. They would make jokes like, "Well I hope they bring back the dresses now." And if you just ignored them it went away. After about three months of being up there it got easier. They knew I wasn't going anywhere and it really did get easier to put up with some of that. Right up until...I was only there six months...and they made me charge nurse. That kind of caused some riffs again. (personal communication, November 14, 2008)

Jonathan was the first registered nurse to work in the rural facility where he had his first job. He worked there for six months and was called into the nursing supervisor's office twice during that time because he was the subject of workplace gossip:

People gossiped about what I was doing. I got in trouble because somebody was gossiping over my salary. I've had to go to the office a couple of times because of rumors that were being spread by these women....[Y]ou should hear the "little chickadees" when they get together they can really spread stuff pretty quick. They must have known someone that we had gotten raises and they were talking about it. So we got brought in and they told us they were going to take our raises away because we were talking about it. This one person said that we were talking amongst ourselves. Well, I didn't even know what she was making and that kind of bothered me because she is a two year nurse and I am a four year nurse and we got paid the same....[I] just think they need to do more when people talk about

other people. Because they won't tell you who says it. Why not? And then it was going around that I was leaving this job because I didn't get this head charge nurse position. Something I didn't even apply for....[W]hy would I apply for a charge nurse position when I had been there only six months? But that was around that place all the time – people talking about other people. Its kind of interesting people coming up to you and say – so, *kind of maddening you didn't get that job....* [I] don't know why I am a topic of conversation. *Talk about something else.* I don't like that I get discussed. I don't talk about you. (personal communication, November 13, 2008)

James (personal communication, December 2, 2008) added another perspective:

It's interesting, Women do one of two things, either they pull all together and it's like this or it's, especially when it comes to women who are in management, they don't respect women who are in management, you know, they do the “pecking chicken” thing, seeing blood and pecking at it until it bleeds more, [they say things] such as, “Did you see what she wore?” “Did you hear how she acted?” You know, going on with the cycles and those various things thrown in. Women complain about men advancing because of the “old boys” club, women are destructive, in fact if they, frequently, typically do not support a woman who is in an administrative position. Instead of, to me, women are always worried about how democratic everything is. There are some things that are not democratic you know. Things have to happen, someone has to be in charge, *not everything is fair.* It would be a wonderful world if it all was but it's not realistic.

Advantages of Males in the Profession

This section contains comments, in addition to those that have all ready been discussed in this chapter, which indicated that the participants believed that the presence of males did make unique and valuable contributions to the nursing workforce. Some of these characteristics were considered to be advantageous and superior when they were compared to characteristics of female coworkers. There were several comments that suggested that an increase in the number of males would comprise a more stable work force within the profession of nursing. Several of the interviewees mentioned that they believed that men were more readily able to put personal agendas aside at work to assist with the goal of placing the patients and what was right for the patients above other issues.

Monte added his perceptions about men who were nurses:

I don't know, they probably, they look at things probably in a little bit less seriousness than women maybe at times. If you do not use humor in what you are doing you're going to be a very depressed individual, obviously. (personal communication, October 27, 2008)

William (personal communication, November 25, 2008) talked about his work experiences:

I have only worked in psychiatry but they tell me where you have a lot of women you have a lot of squabbling and if you can throw a couple of men in there you will have less of that.

"It doesn't get as heated. It wouldn't get as heated with me." (Paul, personal communication, December 13, 2008) Patrick (personal communication, December 10, 2008) stated one reason why he believed that his manager pursued and favored male employees:

I think she feels that there is less bickering between them. And I think she feels that the women sometimes have a quicker tongue to complain to the manager and say "This ain't right, that ain't right." Where I think the guys just buck it up and don't say nothing. I think if you talk to the girls there they will say, how do they say it? "I don't have a penis." or something to that aspect – kind of mocking that she has a favoritism towards males. But I also think is because they complain less.

The participants remarked that they tried to resolve conflicts as they occurred.

William offered the following example: "I don't think I've ever been mad at anybody for more than a couple hours and vice versa. I don't think that anybody is mad at me." (personal communication, November 25, 2008)

Phil shared these thoughts about the advantages of having men working in critical care areas:

It's that things seem to run really smooth when you have guys in those areas you have a lot of crises happening....[G]uys, I don't want to say handle stress better because not all can handle stress better – but when something happens it just seems like the guys are more down to earth and don't lose their heads as quick.

Guys, I don't want to say handle stress better because not all can handle stress better – but when something happens it just seems like the guys are more down to earth and don't lose their head as quick....[F]or example if a code happens on the floor, the guys think of the mechanic stuff. Make sure you have the crash cart there – make sure you get the patient where you can do CPR. Start it right away, that kind of thing where the girls are more worried about, let's get the chart and let's find a doctor type of thing. All of it is important – it's just the order of what they think of first. (personal communication, November 14, 2008)

Jonathan shared “I don't get worked up as easily as a lot of the women that I work with – especially when I worked the ER at [name of a rural hospital].” (personal communication, November 13, 2008)

Christopher (personal communication, October 30, 2008) added:

On our weekend there's three guys working and everybody always wants to get to our weekend. I think it's because we run the ship on an even keel, there's no scatter brains, no highs and lows, we just kind of try to keep it as smooth as possible.... A]nd just different things I think men can bring to nursing, like I said, the even keel that was something that I really noticed after working there about a year is that when Monte was boss versus somebody else, everything seemed to go a little bit smoother. Not necessarily because he was a man, maybe it's his experience as well. He's done it a long time.

William shared that he believed that it was in the patients' best interests for nurses who were male to take the responsibility of accepting more difficult assignments at work:

With women, sometimes they'll [patients] be kind of sexually preoccupied and make snide comments, stuff like that. But usually it's a threat of violence or also they will try to intimidate the women by, or men, by being really rude, wanting extra narcotics or privileges and stuff and they think if they are ugly enough they can get their way. So, it's better for a man to be in there, saying, “Nope.” they're more likely to accept it from us and we don't get intimidated as much....[W]ell you [a male] get the crummier patients because being in psych you know when the nasty people come in, of course, I get assigned which I don't mind but it is true, one male said one time, he says, “Do you ever notice we get all the mean ones and those that need lifting they'll always assign us?” I said, “Yes, and I don't really care.” I would feel really stupid, passing them off on women. I just wouldn't do that. I volunteered, if I come on shift and they'd made a mistake and given some nasty person to a woman, and I'll say, “Do you want to trade?” and I'll take them. Most of the time I get the adolescents and then there is only one nurse over there anyway but if I'm on the adult side, I'll take the nasty ones because I don't care. (personal communication, November 25, 2008)

Many of the respondents shared that they left their work-related problems at work and did not discuss these issues at home. Monte illustrated this point by saying:

A lot of these people are going home at night and can't sleep and can't concentrate because they just can't let go of their work. And I am able, at that point now, where I can walk out the door, still think about it but not to the point where it keeps me awake. I can move on....[I] have nothing on my mind when I am away from this. So it is truly vacation or time off for me when I am away. I love that.... [B]ut men, I think it's easier for us to leave our work at work and it's not as easy for them [females] to walk away and go home and put on this is my "not work face." (personal communication, October 27, 2008)

Patrick who had a wife who was also a registered nurse shared that they never discuss work situations at home. He stated:

You see people beaten and stabbed and you kind of just, you got to kind of get over the emotional aspect of that, disconnect yourself from it. Because if you don't you probably go nuts.... [I] try to keep it as business. Business is business.... [I] hate to get wrapped up in work at home too, you know. I think one of the other things I've learned too is when I slide that card, I'm done. I totally do not come home and worry about work ever. I slide my card in that slide box and I'm out the door and I don't even look back. [Snapped his fingers] (personal communication, December 10, 2008)

Personal Communication and Socialization with Coworkers

Despite, the invisible "thin line" that the respondents described in the workplace, all of the nurses stated an awareness of the value of positive teamwork in the nursing workplace and depicted good communication patterns with their female coworkers.

James's comments illustrated this point:

Communication is generally good. As the saying goes, "We're not related so I am listening to what you are saying or telling you so." Some people vary, depends upon their personality in the first place, there are those who will tell you everything two seconds after you walk in the door, there are those who never tell you anything. And there are those who, over a period of time, develop a relationship and yes, that communication takes place. They all exist at different levels. (personal communication, December 2, 2008)

Richard was questioned if women confided in him. He replied:

Oh, definitely a lot of them. Oh, definitely I'm a person that I feel, is easy to talk to so I believe lot of them come to me and unload their personal problems and they come with problems with patients and that kind of stuff too.... [B]ut sometimes I feel they feel it's easier to talk to a guy than their female peers. (personal communication, December 3, 2008)

Christopher's responses echoed the same sentiment of communication with female coworkers:

Women are just - seems like - are more likely to open up to a man. I got so many gals up there telling me their problems. They just, they don't necessarily share with other women but for some reason they come and tell me. Yes. I hear a lot of personal problems, you know, surprised with marriages. My husband does this, why do they do this? I don't really know their husband that well but they just say, "You're a guy. What's your take on this or?" Sometimes it's more than I want to hear but it's something that they trust a guy more or I'm not sure what it is but I can tell they like having a guy up there. (personal communication, October 30, 2008)

Patrick commented about his similar experiences:

They tell me, yeah. There are things that they tell me that I don't tell other people. There are things that I know that I don't say. Because they trust me that I won't spill the beans on anybody. I don't usually tell on people when I hear stuff - I usually just don't say anything. (personal communication, December 10, 2008)

All of the respondents were confidants of their female coworkers but eleven of the twelve males did not reciprocate the same depth of information to their female coworkers. One of the respondents shared that he would "sometimes" confide in a female coworker only if he has had a long established relationship with that person.

Christopher's reply to the question whether he discusses his personal problems in depth with his female coworkers was:

Telling them problems? We'll discuss staffing issues and just different things that we feel should be implemented at the hospital. More work related problems. I can talk with them about almost anything. I don't get deep into my personal problems with them. (personal communication, October 30, 2008)

James (personal communication, October 30, 2008) stated: "But I will tell them things that do occur, I mean, it's nothing I'm not going to tell them that I wouldn't have told my wife already so. I'd be in trouble if I didn't do that."

The participants in the study did not socialize with female coworkers outside of the work setting. Paul's comments were typical of comments shared by the other nurses:

I don't go out much. Work, home, and the gym, that's me. I don't have many outside relationships. Mine are kept more professional, I will go out with the staff, my coworkers, for drinks or whatever, some time to debrief or whatever, But I'm not much for the interaction. (personal communication, December 13, 2008)

Three of the participants who worked in the telemetry unit did socialize outside of the workplace with one another and participated in annual camping and hunting trips that included themselves and other men.

Committee Work

Many nursing units practiced shared governance models in which committees made decisions regarding unit practices and policies. Many of the interviewees have served on committees at one time. Phil continued to serve on a unit governance committee at the time of the interviews.

I don't like it when things are handed down by committees. I still think, this is maybe where men and women differ on decisions as well, I like to go to my manager and say, "I don't like this, this is what I thought and then I don't like it." I hear "Well, it was decided by the committee." I don't care, so how do I get it changed then, if the committee decided, I can't sit down and talk to you as an individual and say, "I don't like this. This is wrong." Anyhow, it's that you are not able to state your problem to an individual...but yet they have to have others tell me what I got to do....[*W*]ould I love to tell you about the committees [stated with emphasis]. When I started, yes, I was on a planning committee for the floor. We wore white uniforms...and if we wanted to go to colored scrubs, each unit got to pick a color first so every unit had a different color. So, fine, then, all of a sudden, with a wave of the wand, anybody can have any different color scrub. We took two years to get Caribbean blue and raspberry for tele's original color of scrubs...now that is not progress, to me, that was way, too much time to decide a color of scrubs...it's not worth my time. *That was a waste* [raised both hands in

the air] of my time as far as I was concerned. *When we are taking hours of time to decide a color...* I mean, you're not paying hundreds of dollars an hour because you have ten people on a committee and they are listening. That is when I said this is not for me because I cannot tolerate things that move that slow [sic] to do something so simple – so yes I have been on them – I saw what it is and I don't care to be a part of that – something that takes that long to come up with that. But I am not going to be a part of something like that. I like my days off – waste an hour of my time on my day off. (Monte, personal communication, October 27, 2008)

James (personal communication, December 2, 2008) shared his experience with committees:

I have been on tons of committees over the years. I've come to the point now where I don't want to be on any more committees because I'm just, because I honestly don't believe anything really changes. You know, the people who make the ultimate decisions generally do whatever they want, with or without input and I think sometimes committees are just a facade. I've been through that in various capacities even when I was in the IT types of things. "Yes we need to this but we're not going to." I have a hard time really believing that much of anything really changes unless somebody administratively wants it to change.

Patrick shared his opinion about how an increase in the number of men in the nursing profession could change the governing dynamics of nursing units:

I think that having males in the field brings a whole new aspect to the field. I think somewhat that it does provide a better governing body. I feel that sometimes men are less emotional when it comes to governing and like dictating things. It's easier sometimes for us to be more concrete and say, you know what...this is the way the ball is going to roll, *if you don't like it, too bad*. You know, *this is the way it's going to work*. (personal communication, December 10, 2008)

Communication with Patients

Christopher made the following statements in how he perceived differences in communication patterns with patients between the male and the female nurses on his unit:

I've had really good experiences with men. I think something that, at least the guys on our floor do, we pretty much treat our patients like we would treat a friend, that's how we visit with them and we don't treat them like they are ten and I see the way that some of the gals talk to the patients and they almost treat them like children knowingly. Where I don't treat them as like we were sitting on bar stools but I'll have conversations and you kind of feel your patient out and decide

what you can decide, what you can talk about. There are probably things that I discuss with them that we shouldn't discuss with patients but I think we treat them more like a person, at times. We talk about sports or if they talk about drinking I may share a story with them. What I try and do is get them comfortable with me. There are so many patients I will go in and they shy away from you, they don't want to visit but that's primarily what I try to do, I'll joke with them and that's what all the guys up there do...we try and joke with them. I don't know if women feel that they have to be professional more than we do, not that we aren't being professional...it's just their demeanor that "This is the patient, I am the nurse. We're not supposed to be friends." But there's something that all the guys up there - we just kind of treat them like a friend. And they - we've had - Monte and I made the newsletter, one gal wrote in and talked about how much she enjoyed her male nurses. That was neat because it was a hospital wide thing. (personal communication, October 30, 2008)

Adam stated the following:

Like some women – it is usually the women that we are taking care of that are saying that they would rather have a male nurse because we are a little more interested or take – they think we take better care of them. I don't know what we do – we might just be eye candy for all I know but. (personal communication, December 5, 2008)

Christopher (personal communication, October 30, 2008) addressed the times that patients and/or their families were difficult to work with:

The hard shell is: Don't take things personally. Like families have problems. You're the one they take it out on but it isn't necessarily you they are after.... [W]e actually get treated worse than I figured we probably would. You just assume that everybody is going to appreciate what you are doing but the problem is nursing is the middle man for everything. If your diet isn't right, if your food is cold, it's our problem. If the doctor is not here on time, it's our problem. We have no idea when surgery is going to happen and people ask us and then they are mad when we don't know. PT or OT isn't here yet, they are harping at us....[T]he families are worse. I had actually told a family one night that "I'm not here to be your slave." I said "If you don't appreciate what I'm doing. I'm sorry." So I will occasionally set somebody straight if they are way off base.

Communication with Physicians

The majority of the participants reported that they had good rapport with physicians. Paul shared "I think they give me a little bit more leniency. They're pretty quick on the draw with the female nurses." (personal communication, December 13,

2008) Adam stated his beliefs about this occurrence: "I think doctors can communicate better with guys at times. Because most of the doctors that we deal with are men. The guys are less timid to approach or talk to them." (personal communication, December 5,

2008) Jonathan echoed the same sentiments as Adam and added:

I got along with the doctors at my old job a lot better than probably a lot of the females did. Because I had a lot more in common with them do a lot of the same things it was easier to talk to a lot of the doctors. I think it's easier for me to communicate with the male doctors than it was for the women like they were scared of them...like they were going to be yelled at or something. I kind of knew them and was never worried about anything like that. (personal communication, November 13, 2008)

Jack (personal communication, November 28, 2008) shared that being in the minority aided his communication with male physicians at work. "So it's just me and him are the only males in the whole department so we have a little common brotherhood bond right there to start with."

The doctors...they all call me by name, every single one of them. They will walk up and a female nurse will be talking to them and they won't even know she's there, they will be standing there talking to me, they'll totally ignore what that person is saying to them and come to me for the information, even if I'm not the nurse taking care of the patient. And I think that has to do somewhat for a male to male communication. I don't think the female nurses are treated at all with the respect by the male doctors that the male nurses are. I think that, for the most part, they want to be your buddy. It's more like, I'm your "bro". And if you're a female, they are more apt to be nasty to them than they are to a male. (Patrick, personal communication, December 10, 2008)

Phil stated his experiences and observations regarding communication with physicians:

I don't know if this is because of guys or not, but on our floors all the guys talk to the physicians, we joke around and torment them. And we usually get what we need for orders. I don't know if it's because we've been there longer or if it is a guy thing. If we call for an order – like if one of the *girls* (emphasis added) would call for an order, they will call the doc numerous times. They won't get what they need, like Lasix or pain meds or whatever. And if a guy calls we get the order and it is always *because you are a male*. I don't know if it's that or if it's just how you word it. I have listened to some of the calls and if you call and say the patient has a lot of pain but he is better now they are not going to order anything. If you go

and tell him that he is having pain, the order is up. It is kind of how you word it. When I call a doctor I will just say this is why I am calling and leave it at that. I don't give a whole story especially at night when you call - they don't want to hear the ten minute story about why you are calling - they just want to know why you are calling....[If] you don't joke around, you know, you're not going to get that little relationship going and you need that. If they trust you on your assessment, that's huge. You have a lot of foreign doctors....[T]hey probably do treat the guys better because where they come from the women are treated different than they are over here. (personal communication, November 14, 2008)

Adam shared his beliefs:

I think doctors can communicate better with guys at times. Because most of the doctors that we deal with are men...a female that is more fresh would be timid to doctors. The guys are less timid to approach or talk to them....[I] think guys are going to get to the point a lot quicker. That's where *girls* like to throw everything in....[I]'m more of a quick cliff notes type of a person and get to the main point a lot quicker. (personal communication, December 5, 2008)

Monte described perceived difficulties that he has observed with female coworkers who have contacted physicians:

Many times it is the fear of the answer you are going to get. I think the *ladies* are more apt to not ask than to be told not to...to where they really don't care about a "yes" or a "no". At [name of a hospital] doctors get away with a lot of bad treatment or words used on them, onto nurses, and I don't feel that's right. Just have to help the person who gets off the phone crying because they got chewed out. I have never had a problem because of that or I have never had to cry because of that. I'm looking out for the patient and the physician wants to holler at me that is fine. I am looking out for them - you [the physician] choose to do nothing - your choice, I don't care. But, I am looking out for the patient and that I what I always tell them - after they got chewed out - you weren't looking to hurt the patient in any shape or form so therefore taking a chewing out is fine. (personal communication, October 27, 2008)

Not all comments received from the male nurses in this study regarding physician relationships were positive. Richard stated: "I mean, there's challenges with doctors at times with attitude but [paused] with experience you learn to deal with them differently." (personal communication, December 3, 2008)

Christopher (personal communication, October 30, 2008) stated, "The lower level doctors actually treat us pretty decent where the upper level ones they kind of treat you shitty."

It really varies by the physician as far as how much information they want from you or how you're treated whether you're a colleague [paused] or a servant. I mean it really makes a big difference, the newer doctors are more, accept a lot more, are a lot more interactive, accept a lot more input as opposed to the older ones who are, "Here's my charts, take care of them." It's just that a "horse's ass" is a "horse's ass" to everybody, it wasn't based on gender. (James, personal communication, December 2, 2008)

A couple of weeks ago, a doctor and I got into a yelling match about a trauma and afterwards, I told him, I said, "I didn't appreciate that, I don't like being treated like I'm stupid." And I told him my side and he told me his side and that's it, we're, it's done. The patient was cared for in the best possible way and that's where I left it. You're still a little angry that it even happened and you hate that it happened but some of my female coworkers might have held on to it a little bit more. But as I said, I think I can take it more than my co-persons, my female counterparts.... [T]hey talk to each other about it and they will hold grudges. Oh, there's a lot of that when somebody burns a bridge. Do you think they would talk to the doctor directly, no direct communication? No, actually not, they never do. I've witnessed that first hand. If you had a situation, why don't you talk Dr. X or Dr. Y or whoever, talk to them. And what would a female usually say? It's not going to happen... [I]t's kind of like the phrase, "You can let the water roll off your back," kind of like a duck. I think, that some of my coworkers look into it too much.... [I] have kind of bad relationship going with one of the surgeons right now.... [I] don't respect him as a person but I'm still going to say "Hi. How's your family?" Things like that where there's people who would avoid them or say "I don't want to work with him".... [Y]ou take control of the situation and they respect you for that and that's how, that's a bad way to gain respect but I tell you what, it's going to help you out. It needs to be done. (Paul, personal communication, December 13, 2008)

That varies on physician to physician. In your level with them, some respect you more – I mean it's personality – I believe some give you more respect than others. So it is on your level of work or knowing that physician. (Richard, personal communication, December 3, 2008)

Monte also added that he believed that his years of work experience helped the nurse/physician relationship:

Everybody is a little bit different...the response...the doctors are different – so I – yes, do I feel I am treated a little bit better or differently, yes definitely there is no doubt, but they know me and they know what I am capable of doing. They give

me a little different instruction then they would someone that has been one or two years of nursing versus ten plus years. But at the same time I am not going to take any crap. There sometimes comes a point where you have to make them think a little bit too and say, "I was looking out for the patient." At that point sometimes you get apologies from physicians as well. There have been times when they came back and said, "Ooh, sorry about it. You were right and you did a good job." And that makes you feel good. You are not given that very often. You are not given compliments on a daily basis. (personal communication, October 27, 2008)

Part IV: The Verdict Is In: Evaluation of Career Choice

The final phase of the interviews concerned the participants' evaluation of their choice of career. Fixing Things, Praise. Overall Job Satisfaction, Sources of Job Dissatisfaction, The Role of the Media, Would You Do It Again, Recommend Nursing to Other Men, and Selling Points were major ideas that were elicited from the participants in this final phase of the interviews.

Fixing Things

Statements about satisfaction about nursing as a choice of career were varied but many of the comments received from the interviewees had the commonality of seeing patients get better or the perception of having done a good job or believing that things went well in various situations. This perception was reflected by Phil: "Guys want to fix and get them out of there." (personal communication, November 14, 2008)

Some of the examples of satisfaction that were given by the nurses involved a physical "fixing" such as the following statement made by Paul in the operating room "My favorite procedure is a total hip procedure and the reason I tell people is because we rip them apart and put them together." (personal communication, December 13, 2008) The "fixing" did not always involve a physical component but also included psychological components of family dynamics:

As far as the fixing goes, yes, I think all of us as nurses, you know, when I was in hospice, that was one of the big things that I liked, I could come into a mess and correct it all. And I really liked that. You'd have all these family dynamics and I could kind of juggle things around and kind of smooth it all out while I was there. (Patrick, personal communications, December 10, 2008)

Christopher related his feelings of satisfaction with these statements:

This patient is doing really well now and we didn't know if she was going to live or die on Monday. She had pressures in the 60s and just knowing that you might have done something to save her life or the first time I did CPR the patient made it...especially when they don't come out of that situation very often. But just doing that stuff makes me know that I did do the right thing. (personal communication, October 30, 2008)

Adam (personal communication, December 5, 2008) illustrated an event that rarely has occurred in the intensive care unit setting: "It's like taking care of a patient when they are near death and they end up walking out of the hospital, it's great to see that." Jack added that he obtained job satisfaction "When you know you actually made a difference, sometimes it just getting a hard IV stick in a very critical patient....[I]f you accomplish something like that." (personal communication, November 28, 2008)

Definitely the fact that at the end of the day you have a sense that you accomplished something or done something good for somebody. Whether they're thankful for it or not, and that happens [chuckled] very often, it's still rewarding for you as the nurse or should be. (Wade, personal communication, November 18, 2008)

Jonathan added:

It's like you got to feel like you accomplished something or have a good feeling when you took care of a person that came at their worst and then you send them home and they're better and you know, they say "Thank you". (personal communication, November 13, 2008)

Praise

The phrase "Thank you" when spoken by patients and/or their families was frequently mentioned as being very meaningful and fulfilling to the respondents.

James, who had the most years of experience of the nurses in the sample, described a good day at work as:

Some days it's been horrific all day and somebody who had dialysis and had a bad time of it and says "Thank you." And other days, things just click and everything goes smoothly, there's no one defining thing that makes things a good day....[T]he "thank you" probably goes further than anything else. (personal communication, December 2, 2008)

Jonathan, the interviewee with the least amount of experience of all of the nurses in the sample illustrated this point by stating:

You got to feel like you accomplished something or have a good feeling when you took care of a person that came at their worst and then you send them home and they're better and they say "Thank you". They give you a lot of thanks for taking care of them. It's kind of actually fulfilling. (personal communication, November 13, 2008)

Richard previously worked in an area of high technology in the heart catheterization lab but left that area after a personality conflict with a physician who was the director of that area. He stated that he enjoyed his time in the heart catheterization lab but also enjoyed his work in the flex pool that covered transitional care, rehabilitation, psychiatry, and medical/oncology. He talked about satisfaction in the provision of care in his current position:

I actually, get praised quite often, not to brag or anything but I mean I do get praised a lot on care, care for them and comfort....[I]'m a believer in comfort. Trying to situate them the best that they feel and I get a lot of compliments on that. Even in their ADLs [activities of daily living] I get a lot of compliments on the best bath I had the whole time I'm here." (personal communication, December 3, 2008)

Christopher (personal communication, October 30, 2008) shared "There are days when I questioned did I do the right thing but if you make one person's day, you can overlook the two or three families that treated you crappy." Some of the expressions of thanks that

were received by the nurses were in written form. William showed me a note that he received from an adolescent girl prior to her discharge from the psychiatric unit.

She handed this to me before she left. I was just flabbergasted. The thing she wrote to me – when I was racing motorcycles – I had trophies. Boxes of them. *But this is more than my trophies.* Her dad had passed away and she said, “I had to let go of him and you helped me do that.” She wrote, “You are the coolest old stranger that I have ever met. I want to be a crazy old person like you. Not an old mean fart. I believe in God.” Now that is pretty awesome.” (personal communication, November 25, 2008)

Christopher (personal communication, October 30, 2008) voiced satisfaction with his career decision because of the knowledge base that he obtained as a nurse:

Actually it’s more gratifying than I thought because like I said previously I thought it was pretty much just checking vital signs but now I know what the patient needs, I’m not saying that I’m as smart as the doctors, but you start to know what to expect. Now, I’ll call a doctor and say this patient needs Lasix or I think they need they need a chest x-ray and as you develop that closeness with some of the doctors, they trust you so they know when you’re telling them these things, “Hey, he knows what he’s talking about, we better get that done.”

Overall Job Satisfaction

All of the interviewees enthusiastically stated that they had overall job satisfaction working as registered nurses. Paul stated, “I enjoy what I am doing. I found my niche.”

(personal communication, December 13, 2008) Richard (personal communication, December 3, 2008) shared, “Yes, I am pleased I’m a nurse.”

Monte (personal communication, October 27, 2008) cited:

I am a very happy individual for the most part and I love what I do. I think that shows on my job most days. I love what I do and I enjoy where I am at, enjoy my bosses, my organization that I work for and I plan on being there a long time unless something changes that or I get frustrated enough to go someplace else. But at this point I don’t see why that should happen.

Patrick shared:

Oh, I love working as a nurse. Yes, I don’t know what else I would do any more. There is the ability to function freely within your guidelines. To be autonomous in

your care, to be a leader, to be someone that other people come to for advice.
[Pause] I enjoy that *totally*. (personal communication, December 10, 2008)

James (personal communication, December 2, 2008) shared that one of the most satisfying aspects that he found as a nurse was in “being able to render personal care.” William (personal communication, November 25, 2008) related:

Oh, I get to work with the adolescents and I [pause] connect with one or two of them probably *one* – because sometimes it takes two weeks to make a good connection. And we sit down and have a long one-on-one discussion about things. And I share things with them and they share things with me. And I feel like I am in the right place. I like being with people. I feel that at times that God wants me to be there. At times I minister to people. I like to work indoors. I like working only 40 hours a week instead of ninety like on the farm. So it is good – some days are better than others but overall I have never ever said I wish I hadn't ever done this.

Phil, who was a settler, stated: “I'm glad that they [his sister-in-law and wife] talked me into it. It's something I can see myself doing all the way down to the, until I'm done working. (personal communication, November 14, 2008)

Sources of Job Dissatisfaction

All of the interviewees expressed concerns about external constraints that were being placed upon their jobs by various outside sources. James's statement provided a summary of the participants' feelings:

I still enjoy taking care of people and helping the other things that go with it, the rules, the regulations, the policies, the procedures, the federal mandates, the joint commission, things are just, they are, they wear on a person after a while.
(personal communication, December 2, 2008)

The majority of the respondents have been impacted by institutional and societal changes and their job expectations have increased. Monte (personal communication, October 27, 2008) related:

The only thing that frustrates me, the technology has moved into nursing like everything else to the point that sometimes you're not in the room doing what my

aspirations or expectations were: Taking care of people....[Y]ou can't sit there and give them the time. Many times they like to visit. And in the morning I don't have time to visit. It is when they hand down things – when they keep adding things that JACHO [an accrediting commission for healthcare organizations] requires....[T]hen everyone is worrying about being sued, I know that wasn't around years and years ago. So everything that you do is – I can maybe get by not charting the little stuff but if something goes to court I better have this documented somewhere.

Paul expressed concerns about government reimbursement for procedures and about difficult patient cases in the operating room, “When they don't have a good outcome, you worry about litigious, you know, litigation, you're worried about the standards, the Joint Commission Standards [JACHO] [rolled his eyes], they're making things tougher to do.” (personal communication, December 13, 2008)

The philosophy for the emergency room used to be “treat them or street them or take them upstairs.” Now you do huge medical work up on some patients we will have patients down there for four or five hours. Easily, routinely. It is just like floor nursing almost because they are there, they're getting their MRIs or CAT scans or lab tests and because the way it's set now that you got to call the hospital to admit people and they almost want a diagnosis before they admit the patient.... [W]aiting time and our volume has gone up too. I remember when I first started, 17 years ago, we saw 800 patients a month, that was considered a busy month. Now we are seeing over 2,200 patients a month now. That's just the way it's gone. It's not just us, it's every ER in the country, it's the same way. (Jack, personal communication, November 28, 2008)

The external forces directly affected Patrick's employment status with his first job.

And there were some changes in the regulations with hospice and things and I was just having trouble adapting to it so I decided I was going to try something different. Big changes are coming. (personal communication, December 10, 2008)

Jonathan stated a wish to return to the rural hospital, where he remained on a “help out” status, after his wife graduated from college. The majority of the workers at that hospital did not receive pay raises that year. He expressed uncertainty about the future of that institution:

If the hospital stays going...I think if it were owned by the town it would do really well– but it is owned by a corporation and our hospital actually is a really busy hospital. There is usually an average of ten people in – which is really pretty good. And the clinic is usually full every day. They see a lot of patients but when you are giving all your money to the large corporation and they have all these small hospitals that don't make anything it shows a loss. I think that is really why a lot of people were upset about not getting raises because you know the place is making money and they get mad that the higher ups are going, like, to Vegas for meetings and our nurse manager goes to Texas for a thing on charge nurses. *You couldn't go like to [an in-state locale] and do that?* (personal communication, November 13, 2008)

James stated that changes were impacting the area of dialysis in the country and that these changes were going to be imminent for patient care for this specialty in this state. Registered nurses were in the process of being replaced by aides who received a few weeks of on-the-job training.

So we provide a level of care those other folks don't approximate in any way, shape, or form. That's what's coming. It's all because nursing administrators [put hands up in the air] want to do it cheaper. (personal communication, December 2, 2008)

The Role of the Media

None of the research participants voiced opinions that the depiction of males who were nurses in the media had any impact on their personal or job satisfaction. Half of the participants did not routinely watch television or go to movies. However, the participants who did watch television on a regular basis quickly related detailed perceptions regarding the projection of the images of male nurses and the entire nursing profession in that medium. The movie *Meet the Parents* was mentioned by the majority of the subjects as the only movie where a male nurse was a featured actor. The subjects stated that this movie was brought up as a conversation item by their friends on a frequent basis.

You don't see many nurses who are male. You don't see many at all, it's all female. Gosh, I'm trying to think who [long pause]. *ER*, there's the black guy who was, yes, I think he was a nurse. He was a bigger guy, he was on the first few

seasons I think he was a nurse. But that was the only one that I...he was either a nurse or an aide. That's the only one that I really noticed because it's always *Sam* [a female nurse] or in *Gray's Anatomy* there's never male nurses, there was one on *Scrubs*. But again, he had an affair with a female doctor. But they don't have any real strong male personas out there. (Paul, personal communication, December 13, 2008)

Jonathan, who was another avid television viewer, shared that male nurses were rarely seen on real life medical dramas and on television medical series:

They usually show the nurses as being stupid. Just it kind of shows the nurse being dumb. They never show the guys it's *always the girls*. They never show a male except that one guy on *Scrubs*." (personal communication, November 13, 2008)

Phil (personal communication, November 14, 2008) commented about catalogues that marketed to nurses: "They got like a twenty page book, eighteen pages for the girls and the guys are on the two pages in the back of it." James was one of two respondents who mentioned a national media campaign to recruit people into the profession of nursing that positively depicted nurse who were male:

I noticed like Johnson and Johnson was promoting nursing and there's three people they always show. There's a white lady, a black lady, and a white male nurse. They don't show a black guy as a nurse. It's always a white guy but it's the way it goes." (personal communication, December 2, 2008)

There was a Johnson and Johnson, they are doing an ad campaign. They got these guys sitting there "tough and strong". You know, one guy is a kick boxer or does Tae Kwon Do black belt or whatever, he's an ICU nurse, the other guy does something "manly" he's a male nurse so I mean they are trying to get that out there that, yes, nursing is a profession for males. (Paul, personal communication, December 13, 2008)

James made the following observation about local news media events:

There's still not a lot of it [publicity about men in nursing] and still most of it comes from the idea it's a novelty. [Raised both of his hands in the air and made quotation marks with his fingers] "Hey look there's a guy in there too" and that's a big part of it, it's like "And we have men on staff? *Woo*. [Sat forward and his eyes got bigger] I mean, that shouldn't be a selling point of doing it that way. I recall they had done a story on somebody who worked in ER, he was a guy, they

made a big deal out of the fact that he was a guy. You know, it's just a man who happens to be a nurse. It shouldn't be just because they are a male nurse or a man in nursing. It should be because they are a nurse not because of their gender. Until it comes to that point, when they quit treating it as a novelty then it will be fine. (personal communication, December 2, 2008)

Many of the participants voiced the opinion that increased positive exposure of men who were nurses to the public would increase the numbers of men who would choose nursing as a career. Patrick, a settler who became a nurse after trying other occupations, believed that the impetus for men to enter the profession of nursing would accelerate if men who were nurses were more visible to other men. He stated:

See I never felt that I was looked down on for being a nurse. I never felt that way since day one. My vision has always been that it's acceptable. And I think what will happen is more and more as more and more male nurses enter field [pause] more and more will go into the field. (personal communication, December 10, 2008)

Would You Do It Again?

The interviewees were asked to reflect on their career and were asked if they would make this career choice again. All of them stated that they would choose nursing again but there were different intonations of enthusiasm woven into their words. The majority of the answers did imply a high degree of zeal. Two of the respondents were happy to be in nursing but may have opted for a career in power plant technology and one of the respondents planned to continue to get intensive care experience in the hope of becoming a nurse anesthetist.

Adam related this answer "Yes. Definitely. I really can't see myself doing anything else." (personal communication, December 5, 2008) Paul quickly stated "Absolutely, I think of the great experiences that I've gained and the things that I've seen. Absolutely. I would do it again." (personal communication, December 13, 2008) Monte

(personal communication, October 27, 2008) said “You bet. In a heartbeat.” Phil stated that he would make the same choice of nursing but “I may have taken a different path in so far as – the small town was hard, but I think it was a good learning experience.”

(personal communication, November 14, 2008)

Recommend Nursing to Other Men

Some of the participants stated that they would not recommend the profession to their sons because they believed that young people could not handle the hard effort that was involved in the work of the nurse. The participants in this study expressed some hesitancy giving blanket recommendations to other males to pursue the career of nursing but stated that they would talk to perspective nurses on an individual basis.

This statement was best illustrated by Jack who stated: “You do have to have somewhat an aptitude *that you want to help people*, it's not something you just walk off the street and say, ‘Gee, maybe I should be a nurse.’” (personal communication, November 28, 2008)

Adam cited: “I'd make sure that they were going, wanted to do it for the right reasons, not thinking it might be easy.” (personal communication, December 5, 2008)

Christopher, who entered the profession of nursing with the intentions of becoming a doctor, gave the following advice for others regarding nursing education:

I'd probably tell them they have to be serious about school. And it's something they are really going to have to dig into because it is tough to get in, it's tough schooling and if you're not really serious about school, you might as well not consider nursing. Because I would think it's one of the more difficult programs. (personal communication, October 30, 2008)

You know, I think that would be individualized, I would have to know the person a little bit or know what type of person they were and I would give them all the support in the world if that's what they want to do, if they thought about it

rationally and if they're not going in for the money. (Richard, personal communication, December 3, 2008)

William (personal communication, November 25, 2008) gave this account of his opinion about this subject:

I am not one to talk people into things, unless I thought it was a right fit for them. If they were the kind of person who had probably worked as an aide somewhere or was fascinated with the human body, anatomy and so forth and I would say "This is the place for you." It's good work. It's meaningful much of the time – most of the time you will be doing interesting stuff and you will be dealing with people if you like people. But just the average guy on the street I wouldn't necessarily recommend it.

Wade (personal communication, November 18, 2008) related:

I think I would encourage them if that's what they wanted to do. But I would make sure I discussed all the pros and cons with them so they understood that it's not all miracles and it's not all wonder stories, you know.

Monte shared his thoughts about the person who was suited to pursue nursing:

It takes the right individual to do those things, not everybody is cut out for everything and this is one primarily female dominated profession. If you can care about someone, you're good for the profession....[Y]ou have to be very tolerant of other people's behaviors. You have to give more than take, that is the nursing profession to me. I, many times can go with the punches but many times I have to bite my tongue so it's really hard. You have to have empathy, you have to feel for people, you have to feel what they are feeling without having to experience it. (personal communication, October 27, 2008)

Jonathan (personal communication, November 13, 2008) shared the follow perspective:

"I'd still recommend getting into health care. I'd look at a lot of the other health jobs. It's good but I wouldn't go around recommending it to everybody."

Adam (personal communication, December 5, 2008), who worked in the intensive care unit, related "You have to be compassionate and work as a team. It's not an individual sport. [Laughed] [This is] *definitely not an individual sport.*"

The nurses stated that they would want potential candidates to be aware of the realities of working as a nurse before making the decision to pursue nursing as a career. Jonathan noted: "There's so much responsibility as a nurse, you always have to work the night shifts. I really have trouble with them....[A]nd you always have to do the twelve hour shifts." (personal communication, November 13, 2008) Richard stated he would "look at different fields where the money is probably better.... [I] never liked nights but with nursing you are there until you get up the ladder." (personal communication, December 3, 2008) James added "The schedule, if you end up working weekends....[T]hey lose their charm. [Gave a knowing look] I mean, it's the truth." (personal communication, December 2, 2008) Adam (personal communication, December 5, 2008) stated "I would say you have to be willing to do shift work, nights, evenings." Patrick said "But it is a difficult life. If you are going to provide direct patient care that's brutal. You're going to work a lot of hours and they are going to be rotating shifts." (personal communication, December 10, 2008)

Christopher related the following perspectives:

Are you prepared to work with all women? Is that something you are really raring to do? We have a lot of people complain about working nights and I don't know if they went into nursing thinking that you didn't have to do nights and holidays because that was something that I picked up real quick is that I would be doing nights and I would be doing holidays. That shocked some people for whatever reason. (personal communication, October 30, 2008)

Adam added "You have to have the stomach for it. By one way of saying it because you got to deal with all the bodily fluids and whatever. It's not a clean environment by any means." (personal communication, December 5, 2008)

Selling Points

All of the participants offered suggestions that they thought would appeal to males who were considering careers as registered nurses. Jack stated, "People think that it's bedpans, whatever they say, it's not about that, there's more to that, as you know and I know, there's more to nursing than that." (personal communication, November 28, 2008)

The opportunities of mobility within the career and advancement through education were frequently cited as selling points for males to enter the profession of nursing. Advancement was mentioned frequently by all of the respondents. Jack (personal communication, November 28, 2008) stated, "In nursing if you want to advance your education, advance your pay scale, there are certain options you can do, you can do anesthesia, or you can do the administration part of it, if that's your thing." Phil said, "I think we had three in our class and I am the only one still just working the floor. The other two have gone on to anesthesia and moved onward." (personal communication, November 14, 2008)

Paul stated:

Because, you know, there's not many nurses, even on the floor that are, there are a few males. But not many. Most of them have advanced through the chain. I think that's why they come into nursing is to go, to keep moving up the ladder. (personal communication, December 13, 2008)

There are always opportunities just to learn more. There's the lateral movement thing with nursing. You can go from different areas of nursing, from pediatrics to NICU [neonatal intensive care] to ICU [intensive care] to KDU [kidney dialysis unit] to psychiatry, there's so many. Or the military is another option for males to get into. You're an officer there. So that's another option for males who are looking at nursing as a career. (Jack, personal communication, November 28, 2008)

Wade (personal communication, November 18, 2008) cited:

There's so many different things you can do, so many different areas you can work in and so many specialties beyond that if you want to go back to school. You're not limited...you have different avenues to take. If you didn't enjoy one aspect of it you can shy away from it and find something you are comfortable doing or something you enjoy.

Richard (personal communication, December 3, 2008) added:

Because they always told me I could branch off to so many different fields. Plus there is a need – there should be a job wherever you want to go or in any area. You could move anywhere – you need health care somewhere. You learn a lot. And a lot of them branch off into anesthesia. Tell them that we don't always have to stop as an RN.

If I didn't like floor nursing, I could do clinic nursing, I could go back to school. I guess you can move up and be like a nurse practitioner, PA or something like that, move up. But if you state a lot about the advancement and make sure you make a point what you do to go into the PA programs, the Nurse Practitioner programs, the CRNA, tell them a lot of the stuff that's above and beyond that you can go and do because maybe a lot of people might not do it eventually but show them that there's a lot that you can do in nursing, not just work the floor, there's a lot more opportunities. (Jonathan, personal communication, November 13, 2008)

An approach that was suggested to attract males into nursing was to stress the areas of work that involved the adrenaline rush that was associated with various areas of critical care.

I think what they, for the men, I'd say hit the areas like the ER, ICU, good start for advancement into other fields or going back to school. I think with the males it's, you're going to do better hitting the exciting things, the challenges that happen in nursing. Probably leave out all this, you know, the stereotypes, you know, cleaning up patients and stuff, I don't think that's anything to talk about. Talk about the benefits of being nurses, the sense of accomplishment. (Adam, personal communication, December 5, 2008)

Jonathan added that a positive approach to entice men into the profession of nursing could be to expose them to the acute care setting.

Stress a lot of the more acute care, I think males actually work better under stressful situations, actually work better together. I'd stress more of the acute care,

show them a lot more of it, actually let them interview with people that work with acute care stuff. (personal communication, November 13, 2008)

The twelve hour shifts were noted to be one of the advantages of being a registered nurse for most of the respondents. Monte adamantly stated, "That is why I do what I do because I don't like the five days a week I love my three twelve hour days."

(personal communication, October 27, 2008) Christopher (personal communication, October 30, 2008) added:

The 12 hour shifts are so nice that I have more time. I'm off more than I ever work in a month. I very rarely have to take vacation because of that, I have my scheduled week off every three weeks so that's been really nice because not many jobs where I can take a vacation and not have to actually use vacation.

Job security was cited as another selling point to attract men into the profession of nursing. Wade said, "Another pro is there are people losing jobs like crazy now days and they can't find enough of us [nurses]." (personal communication, November 18, 2008)

Phil (personal communication, November 14, 2008) cited:

It was good pay and the guys can get in anywhere. [It is] physical, as a lot of other jobs, but it's fulfilling. It's decent pay, you literally can go anywhere – if you get transferred or something you can – if your wife goes somewhere you can go there and find a job close. It's a good profession....[Y]ou can never get bored.

Patrick explained that he never went through a formal interview to obtain a job as a registered nurse in the areas of hospice, long term critical care, and the emergency room.

He described how he obtained his current job:

I put in an application to work on the floor with the same type of patients that I cared for at [long term critical care facility]. I had never even thought about working in ER. Can you believe this? The phone rings, and it was [name of the manager of the ER] and she goes, she saw my application and I don't know where she had seen it. But she said, "I see you applied to the floor." And she said, "You have got to be kidding me, wouldn't you rather work in ER?" And I said, "I never thought of it." I said "Yeah." So she said, "Come in and I'll hire you." And so I went in and I got hired...that is how I got into ER. I wasn't even applying – I was applying for another area because of my experience with those types of patients....

[[N]ame of manager] has a favoritism to guys....[I]f you are a good nurse and you are honest, you are going to be rehired or hired across the street, just like that. I've never – I don't think I have really filled out an application when I went to get a job. Really. It was nothing for me to get a job – all I had to do was call up somebody and say, "I want to work there, can I get a job?" and I was in. (personal communication, December 10, 2008)

Jack added:

There are opportunities, there is always a job, job market for a competent male – female nurse a four year degree RN even the top ten safe jobs. That's something they need to research to make sure it's something they want to do the biggest thing is there's job security and goodness gracious there's jobs anywhere you want to go. (personal communication, November 28, 2008)

. Phil related that males who were nurses had a distinct advantage in the area of job mobility of being hired more readily than female nurses. The following statement that was made by him was clarified by the researcher to see if he believed that this statement specifically referred to males who are nurses and not to both male and female nurses. He replied that this statement applied to males who were nurses:

If you like the patient care you stay in the hospitals. You can just go anywhere. It's like having a "get out of jail free" card. You can do anything that you want. I can't think of another profession that you can do that with. (Phil, personal communication, November 14, 2008)

Summary

All of the participants were very agreeable to participate in the study when they were first approached by the researcher but it took a great deal of effort to schedule a time to conduct most of the interviews. During the interview process all of the participants appeared to be cooperative, receptive, and attentive. They were very open to share their lived experiences as registered nurses and appeared to share these experiences freely with the interviewer.

A wide range of emotions was generally seen during each interview. One end of the emotional spectrum of the interviews included the appropriate or inappropriate use of humor to minimize situations as they were described by the interviewees. Humor laced with some sarcasm was frequently used by the participants throughout the interviews especially to describe experiences that dealt with the gynecologic care of female patients. This spoken behavior validated with the interviewees' reports that they approached work situations less seriously as their female counterparts and took more of a "positive" attitude in the workplace. This end of the emotional spectrum also included the sharing of statements that implied that males were dominant in certain work situations. Accounts that were shared about working with females were shared in a knowing manner that suggested superiority on the part of the males. Comparisons of work behaviors between the sexes were readily shared. The opposite end of the emotional spectrum of the interviews involved the disclosure of circumstances that suggested a great deal of vulnerability by the participants. The dominant or "macho" image was not seen by the interviewer during the description of these events. Nonverbal behaviors exhibited during these portions of the interviews included the softening of voices, loss of eye contact, and one participant had tears well in his eyes. The responses by the interviewees to these situations that implied vulnerability varied from developing a philosophical perspective of personal or professional growth experiences to the verbalization of frustration to the interviewer. A straighter posture, the clenching of fists, and the pointing of fingers were nonverbal behaviors that accompanied these comments. The situations that invoked vulnerability to these subjects ranged from personal events such as being the frequent source of gossip in a rural hospital or having nursing instructors use intimidation tactics

to manipulate them during their educational experiences. Vulnerability was also seen in response to national trends that include increasing legal mandates and/or budget cuts that could decrease the quality of patient care and could include change in access and the delivery of patient care.

The interviewees did not appear to be hesitant to share their personal opinions and perceptions with the interviewer. The responses that were elicited were very candid and the male interviewees were not afraid to express their beliefs, which were sometimes sexist, to the female interviewer about women and the female-dominated profession of nursing, and the advantages of being a male in that field. Although the concept of masculinity was not directly questioned the interviewees asserted masculine identities to the researcher during the interviews. This prevailing distinctiveness became evident in some of the answers and some of the examples that were cited during the interviews as well as in conversations that occurred prior to and after the interviews. Marital status, stories about children, home and car repairs, hunting, fishing, water sports, and sports on television were frequently mentioned during these encounters. One of the interviewees showed the interviewer his extensive gun collection, and mounted animal trophies that are contained in the basement of his home at the conclusion of his interview.

In the following chapter there will analysis and further interpretation of the data that was obtained from these interviews for emergent categories and themes. The data analysis will conclude with a final assertion for this research study.

CHAPTER V

INTERPRETATIONS, DISCUSSION, AND RECOMMENDATIONS

This research study explored the perceptions of a selected group of males who made the career decision to become registered nurses. The interview categories of Making the Big Decision: Choosing Nursing as a Career, Welcome to the Nursing Profession: Educational Experiences, In The Trenches: Work Experiences, and The Verdict Is In: Evaluation of Career Choice were explored. All of the data were analyzed and coded. The predominant categories that emerged from this analytical process were Societal Stereotypes, Women's Work, Working with Women, Vulnerability, Entitlement, and Career Satisfaction.

Societal Stereotypes

Stereotypes affect workers' aspirations, self-image, identity, and commitment. Presently, the quality of the media depiction of the image of nursing is not on an equal professional level as the images that are affixed to physicians. These public images have subliminally reinforced and perpetuated societal attitudes and beliefs that have considered which occupations have been appropriate for men and women (Jinks & Bradley, 2004; Kalisch & Kalisch, 1982). In the past, men have been assigned the role of a physician and women have been assigned the role of the nurses by society-at-large. Although some progress has been made in dispelling these gender assignments, this 150 year myth continues to exist. This myth perpetuates the marginalization of men who enter caring professions, particularly nursing, and devalues their contributions to a profession that has

a secondary value and is considered “women’s work”. The affixing of stereotypes to others often goes unchallenged because the people who receive stereotypical labels are not as powerful as those who affix the labels to others.

Young males are not generally attracted to nursing because of prevalent feminine societal stereotypes that were originated by Florence Nightingale that surround the profession. Men who provide nursing care are commonly stereotyped as homosexuals. The stigma of being labeled as gay is great. Homosexuality was widely viewed as mental illness or psychiatric disorder by the medical community until the 1970s (Irwin, 2005). The classification of an entire group of men as homosexual not only implies a deviation of those men from society’s role expectations but the label also serves as a personal demoralizing attack to both heterosexual and homosexual men. The stereotyping of all men who are nurses as homosexual leads to widespread discrimination against those men in various forms. Homophobic feelings or emotions may not be associated with actual behaviors but latent attitudes against gays may persist (Tejeda, 2004). The continuation of the homosexual stereotype of all male nurses does not serve society well as many men who have the qualifications and desire to be nurses are discouraged from entering the profession.

The society stereotypes that portray male nurses as sexual deviants or aggressors that were described by Anthony (2004, 2006) and Inoue et al. (2006) also affect the image of these caregivers and also discourage men from entering the nursing profession. Patients and their families tend to view actions that are included in the provision of care by male nurses with suspicion and mistrust because of the perpetuation of this stereotype.

The interviewees for this study stated a definitive awareness of negative societal stereotypes that were associated with males who were nurses. Societal stereotypes became personally evident to them when they made their choice to become registered nurses. Parents and wives, if the respondents were married, were generally very supportive of their decisions to become nurses but the respondents received mixed verbal and nonverbal responses from male friends and social acquaintances. The only major common reference that the majority of the research respondents and their friends had as a male nurse was the media portrayal of the inept Gaylord Focker in the movies *Meet the Parents* and *Meet the Fockers*. Some of the participants' "friends" took the liberty to make disparaging remarks in high-pitched voices to the subjects about "the gay nurse thing". The subjects were also commonly called "murses" which is the label that is affixed to a male nurse. The respondents stated that they thought that the ridiculing was "no big deal" or "funny" although Paul, who was a nurse for 12.5 years, alluded to this theme 25 times during his 70 minute interview. It was apparent to the researcher during the data analysis that the negative stereotyping was significant to him because of the number of times that he brought this subject up during the interview although he would not openly admit this fact to the interviewer. Jonathan, a nurse of six months who was ten years younger than Paul, had friends who commonly taunted him about his choice of profession. He experienced some feelings of powerlessness when he did not retaliate to their remarks because it would be "mean" to point out that he had a college education and that they did not.

The majority of the participants did have a close female relative or another close family member who was a nurse when they chose their career. Studies by Brady and

Sherrod (2003), Brown and Stones (1973), and Whittock and Leonard (2003) confirmed this correlation of having a close relative who was a nurse as a positive influence on the choice of nursing as a profession for a male. James, the only participant who did not have a relative who was a nurse either before or after he made his career decision, still did receive some parental advice from his mother when she was a patient in the hospital regarding his future choice of career.

The articles by Brady and Sherrod (2003) and Sherrod et al. (2005) stated that there are very few visible male role models who are registered nurses because the vast majority of nurses that the public is exposed to are female. Nine of the participants considered themselves as very unique when they made the choice to become a nurse although the two interviewees who worked in a hospital setting as a phlebotomist and an orderly did not express these thoughts. Nine of the twelve nurses did not personally know of a male who was a nurse at the time that they made their career decisions. The three respondents who knew males who were registered nurses cited that their family's influences played a much larger role in their decision to become a nurse than knowing men who were nurses. Two of these three respondents worked with nurses who were male in the hospital setting and one of the respondents, who was in high school at the time of his decision, stated that he knew of an older male acquaintance from a neighboring rural county who became a registered nurse. Societal stereotypes became more prevalent to the nurses in this study in the educational settings when they saw that they did not have male role models as nursing teachers and had few male classmates. They saw a limited number of male coworkers employed as nurses in health care

facilities and some patients refused to let them care for them as professionals especially in the area of maternity.

Angrist (1969), Egland and Brown (1988), Evans (2002), and Williams, C. (1992), addressed the deeply entrenched societal beliefs that men who were not employed in traditional professions were not masculine. The respondents for this study shared that they believed that the stereotypes of men who were nurses as not fitting the societal norm of the image of traditional work for men “was there” at times in an unspoken form. Some of the respondents were the recipients of sexual stereotypical remarks by patients and a few of the interviewees were blatantly questioned about their sexual orientation by male patients. They all displayed a reticence to give a blanket recommendation to other men about considering the profession of nursing

The men in this study dealt with negative societal stereotypes since they considered choosing nursing as a career but the majority of them stated that the nonverbal and verbal treatment by others did not seem as significant to them as much as they gained more experiences as nurses. This finding was supported by Simpson (2005). All of the settlers, or the men who entered nursing at an older age after working in other occupations, stated that the negative stereotype of the male nurses did not affect them as much as the younger seekers and finders. This may be due to the theory proposed by Bradby (1990) that those nurses had established personal adult identities prior to experiencing socialization into the nursing profession.

The majority of the more experienced interviewees reported feeling very comfortable with their professional identities but all were occasionally still surprised when stereotypical remarks were made about males who were nurses. Although the

participants generally stated that societal stereotypes did not bother them much, it was interesting to note that they did attempt to emulate a masculine persona through various comments that were made during the interviews.

These twelve men entered a profession that is deemed unconventional by some members of society at various stages of their lives. It did not matter if the men who were interviewed for this study entered the profession as seekers, finders, or settlers they all were the recipients of homophobic comments and sensed nonverbal censure about their choice of career from others. The theme for this study for the category of societal stereotypes was that: The men in this study persisted to pursue a career in nursing despite comments and treatment by some friends and some patients.

Women's Work

All of the research participants were unaware of the role of men in the development of the history of the nursing profession. Nursing educators need to convey the value men's historical contributions to the development of the nursing profession and their legitimate roles as caregivers to fairly portray this history in an accurate manner. The lack of knowledge regarding the contributions of men to the profession of nursing may give the illusion that men who are entering the profession in the twenty-first century are "pioneers" who are starting an unknown treacherous journey into a profession that has always been dominated by women. The lack of recognition of the heritage of men in the profession of nursing can help to perpetuate the societal stereotypes regarding the motivations for men to enter the profession. The general public and the nursing population need to become aware of the legacy of men in the evolution of the profession of nursing. These groups need to have a heightened awareness that nursing was an

occupation that included both sexes long before the emergence of the strong feminizing influence of Florence Nightingale that continues to persist to this day. Anthony (2006) stated that this awareness can alleviate perceptions that nursing is purely “women’s work” and possibly increase recruitment efforts of males into its dominion.

At the time of their career decisions all of the participants were very aware that nursing was dominated by women and that they would be performing “women’s work” which is deemed by the larger society to be of less value than traditional “men’s work”. The subjects stated an awareness that they were paid less for their work than what they would make in a profession that is deemed by mainstream society as a job that is traditionally considered masculine. The belief that nursing is “women’s work” is so deeply entrenched in society at-large because of the wide-spread lack of awareness that nursing became a woman’s profession only after the mid-1800s. Six of the respondents were not open to consider nursing as a career choice option for themselves during high school because that was a “girl’s job”. They made the decision to become a nurse after experiencing employment in other occupations. These settlers, or the nurses who entered the profession after trying other jobs, selected nursing because it appeared to be a stable career that offered lateral mobility within the profession and geographic mobility if they wished to move to different locations. These phases of life with associated factors to chose nursing as a career by men who were nurses was cited by Simpson (2005).

Six of the twelve respondents did not originally intend to remain as nurses for an extended period of time because they had the intentions of “passing through” the role of the basic caregiver to obtain a position of higher status and higher pay within nursing. The three participants, who were classified as seekers, entered college to pursue a degree

in nursing immediately after high school with aspirations of using the nursing profession as a stepping stone to a different career in the field of nurse anesthesia or as a route to medical school. Two of the three finders from this research study sample who switched their major to nursing after one semester of college had the goal of becoming nurses as an avenue to become nurse anesthetists. One of the six settlers, or men who tried other professions before choosing the profession of nursing, entered the profession with the ambition of being a nurse anesthetist. Six of the participants came into the nursing profession with no intentions of remaining as basic patient care providers but at the time of the interviews, all of the twelve research participants voluntarily chose nursing roles which included the provision of direct patient care in various capacities in varying amounts of time. One of the seekers who entered the profession with the goal of becoming a nurse anesthetist was in the process of applying for graduate education in that field at the time of his interview. One of the finders who entered the profession with no intentions of further advancement was beginning a new position in administration as an assistant director in the operating room but would assist with patient procedures on an as needed basis. Mulherin (2007) revealed that many men entered nursing with the intention of using nursing education to advance to positions in nursing administration or nurse anesthesia to increase their salaries and to be elevated from being labeled as “just a nurse”. The findings of this study correlated with the findings that were reported by Simpson (2005) who stated that settlers or nurses who entered the profession at an older age tended to remain close to their areas of clinical practice. This assertion was supported by the data that was collected in this study.

Many of the respondents stated satisfaction with their salaries that they received through their employment as nurses. One of the respondents addressed that nurses who worked in the state of his residence did receive lower wages than nurses who worked in other states with larger populations. Some of the participants worked second jobs to supplement their incomes. One of the respondents worked a second job because he believed that he had time to pursue other interests when he worked two days a week because of being on an “on call schedule” for full days during the weekend in the operating room. Two of the respondents worked three jobs.

The majority of the participants expressed surprise that the nursing curriculum was of high academic rigor and all of them stated satisfaction that they completed what they considered to be a very hard program of study. This finding was congruent with the findings of Okrainec (1990). This factor may be related to the fact that nursing education may be considered “easy” because the profession is associated with the work of women.

A study conducted by Dyck et al. (2009) revealed that men who were nursing students did not feel wholly excluded and were generally satisfied with their overall nursing education. The men in that study perceived that some attempts by the faculty to integrate men into the profession of men were ineffective. The research participants did not believe that they were treated unjustly but were treated ineffectively. They reported that they were accommodated but not integrated during the process of receiving their nursing education.

All of the subjects of this research study reported that they generally had positive educational experiences but sometimes felt like outsiders because of their different approaches to communication and learning than their female classmates. They did not

encounter blatant incidences of discrimination in the classroom but many of the participants referred to a subtle presence of a “female agenda” that was embedded in the curriculum.

These statements were congruent with the observation in the review of literature that the socialization process in nursing does have a feminine approach and is geared toward women (du Toit, 1995). The men in this study generally outwardly complied with most aspects of the nursing socialization process because of the desire to pass the programs of study but internally they were making judgments about what they truly believed what types of assignments would be relevant for their use in the future. The men in this study needed to “think like women” to complete their programs of study but did not necessarily internalize the feminine affective characteristics such as being submissive, relying on group process for decision making, and giving attention to written detail that are part of the nursing educational socialization process. Submissiveness was not seen during the gathering of the data from the interviews for this study. This was evidenced when the participants set the tone of the interviews by frequently using humor and candor, expressing strong emotions, citing decisiveness, and freely expressing their opinions during these conversations. Almost all of the participants viewed most of the written forms that were required for nursing practice as too laden in details. Some of the participants stated that they did not get into specifics with some of the written work that they deemed as useless “busy work” that took too much time away from doing tasks. One of the respondents stated his continued distaste for the required assignments of care plans and kardexes with very strong words and nonverbal gestures 12.5 years after graduation. The vast majority of the participants generally stated that they were not as emotional

about assignments and tests as their female classmates. They stated that the communication patterns of female classmates were seen to be excessive with little or no resolution. The subjects in the study shared that they believed that a great deal of time by their female classmates was spent processing rather than focusing on getting tasks accomplished. These differences in reinforced gender societal communication patterns and task acquisition were cited by Gray (1992) as potential areas of conflict between men and women in educational and workplace settings.

Many of the participants in the study stated that they knew that the provision of basic patient cares were an important part of their jobs but stated that areas that involved high technical skills in “fixing things” were very appealing to them. Kauppinen-Toropainen and Lammi (1993) and Simpson (2004) reported similar findings from their research studies in which men tended to gravitate toward areas that required increased amounts of technical expertise.

All of the respondents empathically stated that they were not comfortable with the maternity experiences that were required of all nursing students and many of their accounts regarding these experiences involved the use of humor accompanied by exaggerated facial expressions. These universal sentiments that were cited by the respondents of this study were also present in the findings of Brady and Sherrod (2003), Patterson and Morin (2002), and Weber (2008). The interviewees for this study did not participate as fully in the maternity experiences as their female classmates, and this lack of participation resulting in a substandard professional training for them in this area. The majority of the participants who entered nursing education immediately after high school especially did not feel comfortable working with the clientele, especially the younger

mothers, in that nursing practice setting. All of the participants stated that they knew that they were not going to be employed in this setting and many did not see the relevance of going through those nursing practice experiences. The men stated that they believed that this area of work was best “left” to female nurses. Similar reports of the sex typing of jobs with nursing were also reported by Muldoon and Reilly (2003) and Williams, C., and Heikes (1993). Although all of the men in this study stated that they did not wish to pursue this area of nursing for employment, the harsh reality is that they were most likely not generally welcomed to participate in this area of nursing as males by female nurses, the female clientele, and the patients’ family members. The patients who generally accepted the male students’ presence were older mothers who had previous deliveries. Some of the participants stated that they were “lucky” to have witnessed a birth that involved the technical surgical procedure of a caesarean section versus a vaginal delivery.

Egland and Brown (1989), Kauppinen-Toropainen and Lammi (1993), and Simpson (2004) referred to the term role identity in which male nurses gravitated toward working in areas that were more congruent with the masculine role. All of the respondents in this study did work in traditional areas that have been considered to be more acceptable for employment for men who work as nurses that were stated in the literature. Ten of the respondents worked in areas that required a high degree of technical expertise. This was evidenced by the fact that eight of these subjects worked in the areas of critical care or emergency treatment. The area of psychiatry has commonly been considered to be acceptable for male nurses because of the long tradition of employment of men in this area. One of the respondents worked full time in the area of psychiatry and one floated to this area with the flex pool. The majority of the respondents stated that

they had found their niche and worked in their respective areas of employment because they enjoyed the type of work that was required in those areas. The nurses who worked in areas that employed more men stated that they did not choose to work there because of the larger number of men but because of the variety and the types of patient care in those areas of work appealed to them. One of the interviewees shared that he and several of his male coworkers have had discussions about the gravitation of men to certain clinical areas in the hospital settings.

The men who were interviewed for this study, who have the privilege of being the dominant sex in the social order, faced many realities that can be associated with a profession that has been assigned a secondary status by society. The model of division of labor in the medical field established by White physicians in the early twentieth century that was cited by Zimmerman and Hill (1999) is still deeply entrenched in societal traditions and in the milieu of medical facilities. The work of physicians is still valued as important by members of the larger society and yet the work of care giving still continues to be viewed as inferior in the medical hierarchy. The participants stated that they believed that the work of nursing was hard and that it involved more use of cognitive, affective, and psychomotor skills than they originally anticipated when they were choosing the profession. Some of the respondents admitted that they were surprised that nursing is often a thankless job. Comments about being on the lower rung of the medical hierarchy, or the “totem pole”, were often made by the interviewees. Although all of the twelve participants held various positions as nurses, a portion of their job roles included the provision of direct patient care. All of the subjects mentioned that advancement in the ranks of nursing that was considered to be “above” bedside nursing could be an effective

recruitment tool for males who were considering nursing as a career even though they have not chosen this route. These career options included the continuation of education to become nurse anesthetists, nurse practitioners, and nurse managers. It was interesting to note that advancement to nursing education was not mentioned once during the interviews by any of the participants. .

The subjects shared that they believed that men who worked as nurses generally enjoyed variety and excitement. The nurses who were employed in critical care, in the emergency rooms, and in the operating room cited that they believed that one source of satisfaction with their jobs was due to the adrenaline rush that they experienced during crisis situations. The acknowledgement of this adrenaline rush by nurses who were male that was cited by these participants was validated by Simpson (2004).

The men who were interviewed for this study chose a nontraditional man's job at various stages of their lives for various reasons. They were often surprised at the rigor of the curricula and the attributes that accompanied a profession that was classified as "women's work" even though they were members of the dominant sex in society. The theme for this category of women's work was that: The men in this study chose a nontraditional type of work, they succeeded in a hard academic curriculum, they chose to assimilate or disregard parts of the feminine nursing socialization process, and have carved out a machismo identity in an area of work in the field of nursing that they enjoy.

Working with Women

The comments that were received about the third category of working with women were usually shared as stereotypical generalities about women that were shared by the participants. These comments were accompanied with a variety of nonverbal

gestures that included the raising of the eyebrows or making quotation marks in the air to convey a certain irony. The majority of the comments received from the nurses were mostly centered on the perceived differences between the sexes in communication patterns and in approaches to conflict resolution. The male participants, who were part of a minority in the workplace, all expressed a keen awareness of those distinctions between the sexes with a readiness to demean or devalue the female nurses' role. The dissimilarities that were cited by the participants mirrored the similar distinctions that were cited by Tschikota et al. (1996). Some of the interviewees also scrutinized other male nursing students and male nurses in addition to theorizing about female nurses during the interviews. The researcher has hypothesized that these distinctions may be a response in part to the male nurses' token status in which they [the interviewees] have been closely scrutinized by female nurses because of their [the men's] minority status in the profession.

One of the realities that the men face when working in a women's profession is the use of the team approach in the workplace to ensure continuity of patient care. This can pose some difficulties for men to work in this type of environment. The men in this study were exposed to this type of collaborative work environment during when they participated in nursing practice experiences that were integrated in nursing curricula. In the review of literature, Gray (1992) cited that women tended to work together as groups in a democratic fashion while men tended to be more individualistic and authoritative in decision-making situations. The areas of the operating room and the emergency room could lend themselves to more of an individualistic approach to patient care because of a shortened one-on-one contact with nursing personnel. Three of the participants in this

study were employed in these areas of nursing. Many of the respondents in this study expressed frustration with the cooperative decision making processes that are seen in female-dominated organizations in the form of committees. They spoke of displeasure in the governing structure of committees, the indirectness of committee decisions to communicate feedback, and the length of time that it took for decisions to be made by the committee process. The men expressed a desire to have a more direct decision making process headed by an authoritative individual who would make decisive judgments that addressed the good of the majority of the workers instead of trying to accommodate the needs of all. These communication characteristics were also described by Gray (1992).

All of the men in the study shared experiences with gossip and personality conflicts that have occurred on the job. They believed that these experiences were unique to a workplace where women constituted the majority of the employees.

The work of Pringle (1989) stated that the tendencies to treat one another in such a fashion commonly occurred in work situations where people believed that they were marginalized and underappreciated. These behaviors were frequently attributed to professions that were dominated by females.

The gossiping was perceived by the respondents to be continual in the hospital settings and most of the participants stated that they believed this communication pattern would not take place as often in the male-dominated workplace. The terms "chickadees" and "pecking chickens" were used to describe women who gossiped by two of the interviewees. The use of the words chickadees and pecking chickens to refer to women could have implied that they [the men] were "above" or had a superior view of this type of communication methodology by attaching the name of an animal to members of the

opposite sex (Hall & Sandler, 1982). It was interesting to note that a few of the men in this study admitted that they took part in some gossip sessions with some coworkers but denied that they instigated any of those conversations.

The research subjects reported that they witnessed intense verbal fighting among female coworkers and that the female nurses held grudges against each other and physicians for prolonged periods of time after experiencing conflicts with them. The participants used stereotypical remarks about females when they asserted that the behavior of the female coworkers vacillated because of the fluctuation of hormones, menstrual cycles, and premenstrual syndrome. There was very little information found in the review of literature that supported these claims that were shared by all of the respondents in a “knowing” manner by the majority of the subjects in this study. These disparaging remarks were most likely made with the intention of maintaining a “male dominance” in their work situations.

All of the research participants stated that they generally did get along well with their female coworkers. They stated that they believed that many women confided many personal problems to them because they felt more comfortable talking to a male instead of another female. Female coworkers were seen to consider the men in this study as a homogenous group by the researcher because of statements that were made by several participants during the interviews. One example of this type of statement was that advice was frequently solicited from some of the interviewees to obtain “male perspectives” of the women’s individual marital problems. The respondents did not return confidences with a mutual depth of personal sharing with the female coworkers and they stated that they tended to talk about topics of general interest. These characteristics in

communication patterns between nurses who were male and female that were obtained in this study were supported by Floge & Merrill (1986).

The analysis of the data for this study revealed that the men who had minority status in the profession constantly scrutinized the behaviors of their female coworkers and spoke of these differences in terms of stereotypical generalities. This finding was also prevalent in the review of literature. The unexpected finding by the researcher was that female coworkers, who were members of the “old girl’s club”, also tended to view differences between males and females in a similar stereotypical fashion. These views, unfortunately, are perpetuating, rectifying, self-fulfilling, and prophesizing. The theme for this category that emerged from this study was: The men in this study established good working relationships with female coworkers in what they considered to be unstable working environments that involved communication patterns and methods of conflict resolution that they perceived to be different, unproductive, and inferior to approaches that would be utilized by men in those situations.

Vulnerability

Many of the respondents alluded to a “thin line” or a heightened awareness of the use of their choices of words and their body language that they experienced when they associated with female coworkers. The interviewees shared many instances in which this invisible boundary that required the use of detachment was used in situations that could be considered inappropriate in the workplace. Some of the interviewees were present at conversations at lunch that were initiated by the women that contained sexually explicit content and the men were not often included in these exchanges even though they were sitting with the group. The “thin line” mechanism was used as a protective response

during these types of situations because of a perceived openness of having various accusations of inappropriate behavior made against them by the female coworkers. Farrell (2005), Fløge and Merrill (1986) and Weber (2008) stated that men who were nurses often experienced similar experiences and that the sexually explicit discussion was part of the “old girl’s club” behavior in which men are purposely excluded from female dialogues and are not welcomed to join those conversations.

The category of vulnerability was also brought forth by the participants when they discussed providing intimate care that involved the genital areas of both sexes. This topic was discussed by Inoue et al. (2006) where refusal by female patients in the area of maternity was commonly experienced by male nursing students. The refusal by patients in this area of nursing was also experienced by the participants in this study. The males in this research study also reported that they commonly had a reciprocal lack of comfort when working with this type of clientele, especially with the younger mothers.

Some of the participants obtained permission from female patients before initiating intimate care and if the patients hesitated or refused, they would trade work duties with female nurses who would perform the procedures. Many of the respondents stated that when they did provide intimate care to females they had another female present during those procedures that were “below the belt” to avoid accusations of sexual inappropriateness. These remarks illustrated to the interviewer that societal stereotypes, often unspoken, prevail in the participants’ everyday work lives. These practices were confirmed by similar practices by other nurses who were male that were cited in Anthony (2004, 2006), Evans (2002), and Inoue et al. (2006). The subjects for this study stated that they believed that they were susceptible to accusations of sexual inappropriateness in

work related situations. Some of these situations involved interpersonal communication with female coworkers and some situations were associated with the provision of care that involved intimate care that involved patients' genitals. The assertion for the category of vulnerability for this study was: The nurses in this study who are male are aware of boundaries of dealing with female coworkers in work situations and with patients in the provision of intimate care.

Entitlement

The nurses who were interviewed for this study readily shared observations about different behaviors that they observed between men and women who were nurses. Many of the comments that were received during the interviews were not value-laden but were shared as observations that many behaviors between the sexes in the workplace that were merely dissimilar.

Some of the examples stated by the participants did imply a tone of superiority that nurses who were male did possess and display advantageous traits in the workplace because of their sex. The men, who constituted an obvious minority in the workplace, did cite differentiations during the interviews that they believed made them superior to their female coworkers. The interviewees stated that these points of demarcation were readily discussed with other males who were nurses and close personal friends.

The greatest advantage of being a male who was a nurse that was cited by the majority of the participants was the camaraderie that they shared with the male physicians. The majority of the participants expressed a great deal of pride in the fact that they could easily converse with physicians. They believed doctors tended to trust them when they [the nurses] called the doctors regarding changes in patient situations. Orders

for patients were more readily received by the nurses in this study than their female coworkers and the males were frequently chided by the females when they did receive these orders. The participants attributed the connection to the physicians to more direct male communication patterns and bonding between members of the same sex. These findings corresponded to the findings reported by Floge and Merrill (1986) and Stott (2004). A few of the participants also stated that they believed that years of experience and longevity on the nursing unit could also have contributed to the issue of the increased trust by the physicians.

All communication situations with physicians that were cited by the participants were not always positive and many of the males suggested that they used a forthright approach to directly deal with the physicians who were involved in those verbal exchanges. The participants stated that they tended to address the priority of patient care when they spoke to the physicians about those situations and were more level headed in these heated situations than their female coworkers.

Some of the participants' statements alluded to the fact that the male presence could contribute to a more "even keel" in the female-dominated workforce. The participants made various comments regarding advantages that they encountered as nurses who were male. They also stated differences in behavior that they perceived to be unlike that of their female coworkers. A predominant code that emerged from the data from the participants was that the men believed that they did not take professional situations as personally as female coworkers. The males generally reported that they approached their jobs more often with of a positive attitude. They stated that they tended to possessed this type of attitude, in part, because they had an understanding that

decisions might not satisfy everyone's needs in the workplace, tried to deal with conflict immediately, did not hold grudges, and did not take serious approaches to personal situations at work.

The male interviewees stated that they tended to compartmentalize work-related problems by not ruminating about them at home and stated that they usually did not bring personal problems to the work setting. There was a tendency among the participants to guard their time off of work to focus wholly on personal activities or pursue other employment. Some of the respondents stated that they enjoyed working 12 hour shifts and believed that the promotion of these shifts would be an effective recruitment tool for other men because of the enticement of having more time away from the job.

The subjects for this study stated that they focused on providing the best care for the patient instead of focusing entirely on themselves in the workplace. They stated that they used humor and treated patients more like friends more often than female coworkers. These findings corresponded with the data that was reported by Inoue et al. (2006) in which men stated that they did treat patients more like friends than their female coworkers. The men in that study stated that they believed that the use of humor was used to make patients more comfortable and more at ease.

Many behaviors that were noted to be different between the men and women were overtly addressed by the interviewees. The intonation and nonverbal gestures that were made by the participants when they stated this type of remark did imply a sense of entitlement and superiority. One covert behavior that exhibited a sense of superiority by most of the male research participants was the use of the words gals, girls, chickadees, chickens, and ladies to describe their female coworkers. The words female or woman was

very rarely stated during the interviews. This finding coincided with the classroom study conducted by Hall and Sandler (1982) in which male professors addressed males as men and females as gals and girls that had the chilling effect of reinforcing male domination. The participants in the current study who addressed women in those terms may be subconsciously reinforcing male dominance in professional settings where female coworkers constitute the majority of the nursing workforce.

Some of the participants in this study viewed their sex as an advantage to obtaining a job. Fløge and Merrill (1986), Kanter (1977), and Williams, C. (1992) also stated that men do have advantages as tokens in the female workplace for hiring and for promotions with nursing. Patrick, a settler who became a nurse after trying several other jobs, never went through a formal job interview to obtain any of the three full time jobs that he held since graduation. He also stated that his current female manager favored hiring nurses who were male. Phil related that males who were nurses had a distinct advantage in the area of job mobility of being hired more readily than female nurses.

The male participants in this study were very cognizant of perceived and actual advantages that they as men often experienced as being registered nurses in the form of entitlement. They reported actual and self defined opportunities that they perceived to be superior to those experienced by their female coworkers. The theme for this category was: The men who were in this study were quick to note differences that they perceived to be dissimilar between the sexes and stated distinct superior advantages of being a male in the nursing profession.

Career Satisfaction

All twelve of the subjects stated that they were satisfied with their choice of nursing as a career although the level of enthusiasm of their answers to this question varied. Some of the respondents stated that they “stuck” through school because they really enjoyed taking care of patients. A commonality that was expressed by the participants was that they liked to fix things and when things went well they felt job satisfaction. The participants acknowledged that the work was hard and often thankless. They acknowledged that they received a great deal of satisfaction when the words “thank you” were stated by a patient or a patient’s family member. The majority of the participants stated that they could not envision themselves working in another profession.

External influences and government requirements that affected the participants’ job autonomy were a source of job dissatisfaction. They stated that they believed that their jobs were increasingly focusing much more on technical, governmental, and litigious obligations instead of serving patients’ needs. The increase in attention to these external constraints was a source of job stress to these interviewees. The interviewees stated that they believed that changes that might adversely affect the quality of health care could affect their future nursing practice in the provision of patient care.

The participants stated that they would talk to prospective male candidates who were considering a career in nursing on an individual basis but would hesitate to recommend nursing to all men because they believed that not all men were suited to pursue the profession of nursing. The participants of this study overwhelmingly stated career satisfaction and stated that they believed that this was the best career choice for them. The theme for the category of career satisfaction was: The men in this study stated

career fulfillment and would not hesitate to recommend the career of nursing to other males on an individual basis.

Final Assertion

The final assertion that was derived for this study after the review of the literature, codes, categories, and themes was: The men in this study displayed strength, persistence, and perseverance to make the decision to become nurses; to finish their education in a timely manner; and to carve out a niche that has given them job satisfaction while maintaining a sense of superiority over female coworkers to work as professional nurses. This assertion was substantiated through the interview process where an inner strength of character emerged from all of the male participants in verbal and nonverbal forms when they shared their life experiences as registered nurses.

The portion of this assertion that addressed the attributes of strength, persistence, and perseverance that was derived from this study is in direct contrast with the review of literature that concerned general society's view of men who are employed in female-dominated professions as inferior and weak. The men in this study displayed very strong personas during the interviews that reflected strength in character while discussing their life experiences as registered nurses. The practice of devaluing and oppressing all that is not associated with dominant male behavior is often unchallenged and ever present in present-day society. Males who enter the profession of nursing are often presumed to be gay because of the strong female foundations associated with the profession that were established by Florence Nightingale. This Victorian influence over the profession has prevailed for 150 years. Although there have been advances in equal rights legislation and practices over the past forty years, attitudes of homophobia continue to prevail

mostly unchallenged in modern day society. The stereotype of men who enter nursing to satisfy sexual perversions has also discouraged men from entering the profession.

The portion of the assertion that addressed the maintenance of a sense of superiority by these subjects was not addressed by the review of literature. Paterson et al. (1996) stated that men who were nurses reported that they were scrutinized because of their minority status. The data received from the subjects of this research project alluded to the fact that the nurses who were male were also very cognizant of the behaviors exhibited by female coworkers that was deemed to be different than male behaviors. Many of the differences that were reported by the subjects were sexist in nature and would not likely be shared with a group of female coworkers. Males who work in female-dominated professions commonly face the dichotomy of being regarded as a member of the “superior sex” in society at-large while experiencing a minority status in the nursing workforce. The labeling of female behaviors as inferior could be the attempt of the male participants in the study, who are the dominant sex in society at-large, to assert their own superiority over the “old girl’s club” in the profession of nursing. The profession of nursing also gives license to male superiority by perpetuating the practice of tokenism that gives distinct males career advantages over females solely because of their sex.

The participants did not view themselves as victims and shared examples in which they encountered difficulties since the time that they decided to become nurses that were instituted by others because they were men. Females are not commonly questioned or have to defend their choice of nursing as a career and nursing educational curricula and the milieu that surrounds nursing education is geared toward the female sex. Women have ready access to female role models and they are not usually questioned for their

motives when they approach male and female patients to provide care. Women constitute a very visible majority in the nursing workplace. The “old girl’s club” that was cited by Farrell (2005) and Weber (2008) is alive and well within the profession of nursing and entrance into “the club” is very difficult for males.

Six of the interviewees entered the profession of nursing to use the education as a stepping stone to other career opportunities and some of the interviewees entered nursing with the thought that the nursing curriculum was easy. These statements could imply that those participants did not believe that they would be affected by the process of nursing education. It was evident through the interview process that all of the interviewees did undergo change from the time that they chose to become nurses to the time of the interviews and they are not the same persons that they were prior to considering nursing as a career. It was evident to the researcher that the interviewees did not merely pass through the nursing education process but became a part of the nursing culture through the processes of change and some professional socialization. This became very apparent to the interviewer when all of the participants overtly made very strong statements about their thoughts and opinions regarding the provision of quality patient care.

The males in this study were also the subjects of intense socialization processes in which they gained the knowledge and skills to become professional registered nurses. The socialization process for all nurses who enter the nursing profession occurs at the time of entry into the educational system. Socialization in this setting includes the learning of the traditions and knowledge of nursing as well as developing the abilities to think and act as nurses. Socialization occurs when the nurses become employed and participate in unit specific orientation programs (O’Lynn, 2009). One part of the

professional socialization process that was not evident in the statements of these interviewees was that when they spoke of female coworkers in stereotypical terms that were most likely learned at home, from the media, and from peers. The process of being socialized and educated in a female-dominated profession did little to change their attitudes towards women as this was evidenced in the comments that were heard during the interviews.

LaRocco (2007) identified a four-stage linear path that men travel in the process of becoming nurses. The first stage was prior to considering nursing which occurred during high school. This author noted that the majority of the subjects in that research study did not consider nursing as a career at this stage. The second stage was choosing nursing because of the awareness of opportunities in nursing and the influence by a close relative who was a nurse. The third stage of becoming a nurse occurred when the males received their nursing education. The participants in that study generally reported positive experiences in school and shared a few incidences that negatively impacted their educational experiences. The last stage of this path was being a nurse. At this stage the men were fully incorporated in the culture of nursing and stated that they believed that nursing was not entirely consistent with the female role. Nine of the twelve males who participated in this study had very similar situations that were described by LaRocco in their journey to become registered nurses and the experiences of all of the participants in this study aligned with the last stage of the path. The participants did become a part of the nursing culture but did not assimilate all of the feminine values that were a part of a feminine socialization agenda. This fact became very evident to the interviewer as many of them voiced traditional societal masculine beliefs and traits throughout the interviews.

Lewin (1951) described the process of successful change as occurring in the three stages: unfreezing, moving, and freezing. The unfreezing stage consists of becoming open to making the choice of nursing and the person is ready to change at this stage. This stage is similar to the second stage of choosing nursing that delineated by LaRocco (2007). The second stage that was described by Lewin is moving and consists of obtaining and integrating new information about the role of the nurse through the process of education. This second stage is congruent with LaRocco's third stage of becoming a nurse. Lewin's third stage of freezing is when the process of change is complete and the person permanently incorporates the role of the professional nurse into their identity. This third stage is similar to LaRocco's fourth stage of being a nurse. The major difference between these two theories that describe change is that LaRocco's theory acknowledged that men who enter nursing adapt to the profession but also retain male characteristics that make them unique whereas Lewin's theory might advocate that the men who enter nursing may become totally submersed in the culture of nursing and may negate their male characteristics in professional situations.

The participants in this study appeared to have positively undergone successful integration of the role of the nurse into their professional lives through the processes of change and the socialization model depicted by LaRocco (2007). The interviewees appeared to have adapted well to their customized roles of professional registered nurses. Nursing socialization processes that include the female characteristics that were described by Hoffmann (1991) of deference, low self-esteem, emotionality, and passivity were not experienced by the men who were interviewed for this study. The researcher concluded that this group of men displayed an adjusted form of socialization to the profession by

retaining the knowledge and skills required for profession practice and by maintaining many previously learned affective male attitudes.

The inner strength and the assertion of dominance in the field of nursing that the participants displayed during the interviews was evidenced in the fact that they were able to function as professional nurses and were able to maintain their personal identities by finding a niche of work that gave them career satisfaction. The category of career satisfaction was strongly supported by the majority of the interviewees in this study enthusiastically stated that they would choose nursing again if they had that opportunity.

Discussion

Men, especially those who fall in the category of settlers, may be an untapped resource to help alleviate the current nursing shortage. The information provided by this study may serve as a resource for those who are involved in making decisions regarding recruitment into the profession, hiring practices, and retention of nurses in the workforce. The awareness of the diversity, the challenges, and the rewards of nursing should be of particular interest to nurse educators and administrators of facilities that employ registered nurses in light of the current and ongoing nursing shortage. Stereotypes regarding the profession of nursing were deeply engrained in mainstream society and in the profession of nursing itself. An increase of the awareness of the role of men in nursing prior to the time of Florence Nightingale and an increased exposure to nurses who are male to the general public may decrease some of the public's opinions and fears that nursing is a career that is suited only for women. It would be beneficial to question societal beliefs regarding the reinforcement of negative stereotypes regarding men who are nurses. Do these stereotypes benefit society in light of the present nursing shortage?

Statistics reveal that current reality that there is not an unlimited pool of women who are willing to fill vacant nursing positions as there was in the past when women were restricted to very few professions that included nursing.

Largely female occupations like nursing, which periodically suffer from shortages of personnel, are not likely to alleviate deficits in workforce numbers by employing men until current prevalent negative stereotypes of men who perform what is considered to be “women’s work” is drastically revised. Myths of homosexuality that surround all men who are nurses need to be dispelled and all persons need to be viewed as individuals who have the freedom to pursue their career aspirations without judgment. Mainstream society’s views of nursing also consider this occupation to be undesirable work for men because of the low pay and the belief that the level of training and skills required to perform this job is too rudimentary to confer prestige on males. Public attitudes lag behind the actual changes in the profession and males who are nurses face these attitudes as a part of social reality (Segal, 1962).

Education of the general public regarding the importance of the work of the nurse is paramount to break the current cycle of societal prejudices that generally exist against the profession of nursing. Media coverage that portrays nurses as professionals who demonstrate critical thinking skills and autonomy is needed to help reverse current stereotypical images. An increased awareness by the general public and the entire nursing population about the role of males in the history of profession of nursing is also necessary to begin addressing the stereotypes that surround nursing as a solely female profession. A possible solution to the recruitment of men into nursing could be the positive publicity of nurses who are male to serve as role models that would be seen by the general public.

National television campaigns have been launched by large corporations such as Johnson and Johnson in the past contained very positive depictions of nurses but their exposure to the public was limited in duration. Publicity of this type needs to be seen on an ongoing basis. Other types of media such as the use of the internet could provide a platform for a more prolonged cost effective media campaign. The numbers of men in the profession of nursing would accelerate if men who were positive role for nurseing were more visible to other men.

Ideally, it would be advantageous to employ male nurses in school and clinic settings for increased visibility of these professionals by parents and by children at an early age. Exposure to nurses who are male could dispel the public's fears and myths about this population. The influence of these nurses on the choice of nursing as a career may not be readily seen immediately when these children complete high school but may play a factor in later life when they may seek a different profession after experiencing employment in other occupations.

In the high school setting, career counselors need to have an increased awareness about the work of the nurse. They need to promote opportunities that the nursing career has to offer male students. The formation of a technology-driven media campaign that would be geared toward recruitment efforts for this population could be beneficial to recruitment efforts for the profession. Health care career classes should be promoted for those who are considering entering the health care arena and the shadowing of nurses, who are preferably male, in various health care settings should be a part of those curricula. The interviewees for this study recommended that male high school students should be exposed to patient care areas that involved technology and a fast paced

environment. Two of the interviewees for this study who completed shadow experiences in high school as well as citations in the literature that stated those “hands on” experiences were very valuable and provided positive encouragement for students to consider choosing nursing as a profession. Nurses who are male should be visible at high school career fairs to visit with prospective students.

Nursing educators need to examine their present beliefs about the socialization process that occurs during nursing education. Male and female nursing students will have different outcomes to nursing’s socialization processes and recognition needs to be given to assimilation of behaviors that do not necessarily fit the traditional feminine nursing mold. Adherence to a rigid gender-based role can inhibit creativity and self expression (Blumenfeld, 1992). Nursing students who are male need to be integrated into nursing programs and not merely tolerated. Nursing educators who are a very influential presence to students need to develop awareness that the viewpoint of all members within the profession that may not necessarily conform to the feminine traditions and the professional socialization processes that were initiated by Florence Nightingale approximately 150 years ago. Changes need to occur in educational settings through the identification and the examination of different approaches to patient care situations. The analysis and adaptation of these differences may make contributions to improving patient outcomes. The focus on embracing diversity and its uniqueness can enable future nurses to be registered nurses who address the health care needs of a diverse patient population (O’Lynn, 2009).

Males who are nursing students need to be mentored in the topics of touch and intimate care. Nursing educators should not merely assume that men will instinctively

grasp these skills that are central to the provision of nursing care through the process of osmosis. Alternative teaching methods such as role playing, discussion of case studies, pair and share discussions, and simulation in various forms could help prepare males for success in the use of these skills in future patient situations. The use of simulation labs and computer assisted technology could also help male students supplement maternity rotation requirements that may not occur during practice experiences in that area of nursing.

Recruiting efforts should not be entirely focused on attracting high school students, or seekers, into the profession of nursing. College professors and career counselors need to recommend nursing as a possible career choice for finders who are males interested in health care and are seeking a change in college major. The interviewees for this research study recommended that all of the opportunities that nursing has to offer should be emphasized to prospective candidates.

The recruitment of settlers, or men who have worked in traditional jobs and consider nursing as a career option, is paramount. The research shows that the greatest increases of registered nurses in this population occurred between 2000 to 2004 (Auerbach et al., 2007; Buerhaus et al., 2009; United States Department of Health and Human Services, HRSA, 2004). Members from this group tended to stay at the bedside to provide patient care instead of moving into management positions. Settlers generally had high job satisfaction with their nursing careers because they experienced dissatisfaction in their previous job-related roles. Men within this categorization placed a high priority on self-fulfillment and job satisfaction (Simpson 2005). This population could serve as a stabilizing force to help address the nursing shortage of basic care providers because

retention rates of nurses in this category could be higher than the other categories of the seekers and the finders. Recruitment efforts for the men who are considering entering the profession of nursing as settlers need to focus educating the public about the need for registered nurses with an emphasis on personal fulfillment and job satisfaction.

Considerations for Future Studies

Several considerations for further research studies surfaced during the completion of this research study. The sole concentration of males for the interviews for this study was to receive a “one sided” view of persons who entered the profession. It is recommended that a similar future study be conducted on both men and women who were registered nurses to compare data for similarities of the research themes. This type of research study could focus on the commonalities that both men and women face throughout the socialization process of becoming professional nurses rather than emphasize differences between the sexes. A recommended future study would involve the deliberate selection and interviewing of equal numbers of the three groups of men who choose nursing as a career. The data that would be received from the seekers, finders, and the settlers would be analyzed to look for differences in recruiting and retention needs for these three distinct male populations within the registered nurse workforce. This study was conducted in a rural state that embodies a small homogenous population and the researcher acknowledges that a more diverse population that would be more representative of the national population and the nursing workforce should be studied. Additional future studies should include the gathering the perspectives of groups of persons who embody other gender roles such as homosexuals, lesbians, and intersex.

Further research studies that concern the recruitment and retention of nurses need to be conducted because of the present nursing shortage. It is the responsibility of all persons who are involved in health care to help create solutions to help alleviate this impending crisis.

Educational institutions, health care employers, professional nursing and health care organizations, and the government all have a role in working to ensure the continued supply of an adequate number of nurses to meet the increasing demands of our aging population (LaRocco, 2007, p. 249).

Conclusion

The public opinion that males who are nurses are “different” will need to shift if enhanced recruitment and retention efforts for men to enter the profession of nursing will succeed. The role of men in the history of the nursing profession needs to be publicized. Men and women experience different socialization processes into the profession of nursing and there needs to be recognition that all nurses can bring forth unique contributions to the profession. Differing approaches to care-giving practices of male and female nurses need to be recognized and valued. The entrenched power of the “all girl’s club” that has been instituted to safeguard the ideals of the nursing profession needs to be reexamined to see if conformity of membership to that ideal encourages progress in the process of encouraging freedom and creativity of thought. The emphasis of differences between the sexes of people who have the common denominator of being professional nurses needs to be minimized. The stereotypical comparisons of differences and the superiority of those perceived variations between male and female nurses need to be curtailed by acute consciousness-raising on both sides to help promote professional unity. The positive promotion of a career in which members of both sexes that have the desire to provide quality care to others needs to be increased. The breakdown of societal

sanctions can increase the numbers of men who are registered nurses who will no longer be treated as “unique persons”. Men who choose and pursue nursing as a career deserve the same respect and privileges that are affixed to the female members of the “old girl’s club” in the profession. Attitudes that address the equality of men and women in society at-large and within the profession of nursing need to be recognized and addressed to help facilitate recruitment and retention efforts that are urgently needed to help the profession of nursing survive.

APPENDICES

Appendix A
IRB Authorization Forms

REPORT OF ACTION: EXEMPT/EXPEDITED REVIEW
University of North Dakota Institutional Review Board

Date: 2/4/2008 Project Number: IRB-200802-237

Principal Investigator: Klein, Julie E.

Department: Teaching and Learning

Project Title: An Exploration of Reasons that Motivated Selected Samples of Males to Enter the Profession of Nursing

The above referenced project was reviewed by a designated member for the University's Institutional Review Board on February 7, 2008 and the following action was taken:

- ☒ Project approved. Expedited Review Category No. 6 and 7
Next scheduled review must be before: February 6, 2009
☐ Copies of the attached consent form with the IRB approval stamp dated February 7, 2008 must be used in obtaining consent for this study.
- ☐ Project approved. Exempt Review Category No. _____
☐ This approval is valid until _____ as long as approved procedures are followed. No periodic review scheduled unless so stated in the Remarks Section.
☐ Copies of the attached consent form with the IRB approval stamp dated _____ must be used in obtaining consent for this study.
- ☐ Minor modifications required. The required corrections/additions must be submitted to RDC for review and approval. This study may NOT be started UNTIL final IRB approval has been received.
- ☐ Project approval deferred. This study may not be started until final IRB approval has been received. (See Remarks Section for further information.)
- ☐ Disapproved claim of exemption. This project requires Expedited or Full Board review. The Human Subjects Review Form must be filled out and submitted to the IRB for review.
- ☐ Proposed project is not human subject research and does not require IRB review.
☐ Not Research ☐ Not Human Subject

PLEASE NOTE: Requested revisions for student proposals MUST include adviser's signature. All revisions MUST be highlighted.

☒ Education Requirements Completed. (Project cannot be started until IRB education requirements are met.)

cc: Dr. Kathleen Gershman

James D. Nelson 02/07/08
Signature of Designated IRB Member Date
UND's Institutional Review Board

If the proposed project (clinical medical) is to be part of a research activity funded by a Federal Agency, a special assurance statement or a completed 310 Form may be required. Contact RDC to obtain the required documents.

(Revised 10/2006)

INSTITUTIONAL REVIEW BOARD
c/o RESEARCH DEVELOPMENT AND COMPLIANCE
DIVISION OF RESEARCH
TWAMLEY HALL ROOM 105
264 CENTENNIAL DRIVE STOP 7134
GRAND FORKS ND 58202-7134
(701) 777-4279
FAX (701) 777-6708
www.und.edu/dept/rdc/regucomm/IRB

February 26, 2008

Julie E. Klein
1901 South Reno Drive
Bismarck, ND 58504

Dear Ms. Klein:

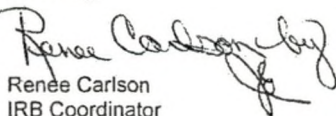
We are pleased to inform you that your project titled "An Exploration of Reasons that Motivated Selected Samples of Males to Enter the Profession of Nursing" (IRB-200802-237) has been reviewed and approved by the University of North Dakota Institutional Review Board (IRB). The expiration date of this approval is February 6, 2009. Your project cannot continue beyond this date without an approved Research Project Review and Progress Report.

As principal investigator for a study involving human participants, you assume certain responsibilities to the University of North Dakota and the UND IRB. Specifically, an unanticipated problem or adverse event occurring in the course of the research project must be reported within 5 days to the IRB Chairperson or the IRB office by submitting an Unanticipated Problem/Adverse Event Form. Any changes to or departures from the Protocol or Consent Forms must receive IRB approval prior to being implemented (except where necessary to eliminate apparent immediate hazards to the subjects or others.)

All Full Board and Expedited proposals must be reviewed at least once a year. Approximately ten months from your initial review date, you will receive a letter stating that approval of your project is about to expire. If a complete Research Project Review and Progress Report is not received as scheduled, your project will be terminated, and you must stop all research procedures, recruitment, enrollment, interventions, data collection, and data analysis. The IRB will not accept future research projects from you until research is current. In order to avoid a discontinuation of IRB approval and possible suspension of your research, the Research Project Review and Progress Report must be returned to the IRB office at least six weeks before the expiration date listed above. If your research, including data analysis, is completed before the expiration date, you must submit a Research Project Termination form to the IRB office so your file can be closed. The required forms are available on the IRB website.

If you have any questions or concerns, please feel free to call me at (701) 777-4279 or e-mail me at reneecarlson@mail.und.nodak.edu.

Sincerely,


Renee Carlson
IRB Coordinator

RC/je

Enclosures

Appendix B
Interview Guide

Interview Guide

The general research question is: What are the life experiences of male professional nurses who chose to provide direct patient care?

Interview categories and subset questions include:

Making the Big Decision: Choosing Nursing as a Career

1. Tell me how you came to make the choice to become a nurse.
2. How was the idea of becoming a nurse sustained from the time that you first had this idea to the time that you started college?
3. Who supported you in your decision to become a registered nurse? If so, in what way did the support manifest itself?
4. Who were people who discouraged you with your decision to become a registered nurse? If so, what challenges did they present to you?

Welcome to the Nursing Profession: Educational Experiences

5. Tell me about your educational experiences.

In the Trenches: Work Experiences

6. Now that you have worked as a professional nurse, in what ways do the original reasons match with the realities of working in the profession?

The Verdict Is In: Evaluation of Career Choice

7. Describe to me if you have found fulfillment working as a nurse. Is this something that you do again, knowing what you know now?
8. Now that you have entered the profession of nursing, what would be your advice to brothers, sons or best friends who might consider becoming a registered nurse?
9. If a new recruiter was hired at to work at a university, what are your suggestions for strategies for this person to attract males to enroll in the nursing program?
10. Do you watch medical dramas? What is your perception about the portrayal of male nurses in these dramas and other forms of media?
11. How have co-workers, patients and family treated you?

Other:

12. Is there anything else that you want to add to what we have all ready discussed? Is there anything that you would like to ask me?

Appendix C
Participant Information Sheet

Registered Nurse Research Study

You are being asked to participate in an educational research study that involves an interview that relates to your reasons that lead you to choose the field of nursing as a career. The name of the study is titled "Male Nurses' Perspectives on Their Chosen Career".

Julie Klein, a doctoral candidate at the University of North Dakota, is the principal investigator for the study and will be conducting the interviews to complete this study.

As a participant in this study, you will be asked to take part in an interview that will last approximately an hour; an additional one hour interview may be required to validate data if needed.

This research will help the investigator gain insight into the female-dominated nursing profession from a male perspective. This information can aid in recruitment efforts to encourage males to choose a nursing career as the profession faces an imminent crucial workforce shortage.

Julie Klein will be contacting you about an interview. You may also contact her at (701) 355 – 8106 (w), (701) 400 – 1594 (c) and at jeklein1901@msn.com to set up a time for an interview.

Appendix D
Consent Form

Consent Form

You are being asked to participate in a study that will explore reasons that have influenced men to enter the profession of nursing. This research study involves interviews that relate to your experiences.

Who is conducting the research?

Julie Klein, a doctoral candidate in Higher Education: Teaching and Learning at the University of North Dakota, is conducting this research project.

What is the research?

The research study is titled, "Male Nurses' Perspectives on Their Chosen Career". The purpose of this study is to record the experiences and major perspectives of males who have entered the profession of nursing.

What will the participants be asked to do?

The participants in the study will be interviewed once. The interview will not last more than an hour. An additional interview may be requested by the researcher to clarify information. The researcher will record the interview using a digital audio recorder and will supplement the data with note taking. After the interview the recording and notes will be transcribed. A copy of the transcribed data will be available for the participant to review and correct. The participants will be informed of the findings of the study upon completion of the writing of the final report.

How much time commitment will there be?

An interview should not take more than an hour.

How will confidentiality be maintained?

All of the names of the participants will be changed in the transcripts and observation notes. The reports of this study will use fictitious names for the participants. The audio files, consent forms, list of fictitious names and any other documentation will be stored in separate locked file cabinets and in a locked desk drawer. Other than persons who audit IRB (Institutional Review Board) procedures, the researcher will be the only person with access to consent forms, audio files, transcripts and observation notes. All files and documents will be stored as described for three years after the research is completed which they will be deleted and shredded.

Who will benefit from the study?

Participants may benefit from this study. The purpose of this research is to gain insight into the female-dominated nursing profession from a male perspective. This information

will aid recruitment efforts to encourage males to choose a nursing career as the profession faces an imminent crucial workforce shortage.
Whom to contact?

If you have any questions about the research project contact Julie Klein at (701) 355-8106 (w) or (701) 258-8781 (h), Division of Nursing, University of Mary, 7500 University Drive, Bismarck, ND 58504. If you have questions regarding your rights as a research subject or if you have any concerns or complaints about the research, you may contact the University of North Dakota Institutional Review Board at (701) 777-4279. Please use this telephone number if you cannot reach the researcher or if you wish to talk with someone else about the study.

Voluntary Participation

Participation in this study is entirely voluntary. You may refuse to participate in the study and this will not result in a penalty or loss of benefits to you. You may choose to discontinue your participation at any time; any of your files will be destroyed with no adverse consequences to you.

Your signature below indicates that you have read the consent form and understand its contents. You will sign two identical consent forms; you will keep one of these forms and the other will be retained by the researcher.

Signature of the participant

Date

REFERENCES

- Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *The Journal of the American Medical Association*, 290(12), 1617-1623.
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clark, H., et al. (2001). Nurses' reports on hospital care in five countries. *Health Affairs*, 20(3), 43-53.
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *The Journal of the American Medical Association*, 288(16), 1987-1993.
- Aljunid, S. (1996). Computer analysis of qualitative data: The use of ethnograph. *Health Policy and Planning*, 11(1), 107-111. Retrieved October 6, 2009 from <http://heapol.oxfordjournals.org/cgi/reprint/11/1/107.pdf>
- American Hospital Association (2001). The hospital workforce shortage: Immediate and future. *Trendwatch*, 3(2). Retrieved July 15, 2009, from www.aha.org/aha/trendwatch/2001/twjune2001.pdf
- Anfara, V. A., Brown, K. M., & Mangione, T. L. (2002). Qualitative analysis on stage: Making the research process more public. *Educational Researcher*, 31(7). Retrieved August 4, 2008, from <http://www.jstor.org>
- Angrist, S. (1969). The study of sex roles. *Journal of Social Issues*, 25(1), 215-232.

- Anthony, A. S. (2004). Gender bias and discrimination in nursing education: Can we change it? *Nurse Educator*, 29(3), 121-125.
- Anthony, A. S. (2006). Tear down the barriers of gender bias. *Men in Nursing*, 43-49.
Retrieved July 23, 2009 from
<http://www.nursingcenter.com/pdf.asp?AID=658434>
- Apple, M. W. (1986). *Teachers and texts: A political economy of class and gender relations in education*. New York: Routledge & Kegan Paul.
- Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2007). Better late than never: Workforce supply implications of later entry into nursing. *Health Affairs*, 26(1).
Retrieved July 15, 2009, from
<http://content.healthaffairs.org/cgi/content/full/26/1/178>
- Barker, K. L. (Ed.). (2002). *Zondervan new international version study Bible*. Grand Rapids, MI: The Zondervan Corporation.
- Bartfay, W. J. (1996). A "masculanist" historical perspective of nursing. *Canadian Nurse*, 92(2), 17-18.
- Bell-Scriber, M. J. (2008). Warming the nursing education climate for traditional-age learners who are male. *Nursing Education Perspectives*, 29 (3), 143-150.
- Bernard Hodes Group. (2005). Men in nursing survey. *Hodes Research*. Retrieved July 9, 2009, from
www.hodes.com/industries/healthcare/resources/research/meninnursingsurvey.asp

- Bielby, W. T., & Baron, J. (1984). A woman's place with other women: Sex segregation within organizations. In B. Reskin (Ed.), *Sex segregation in the workplace: Trends, explanations, remedies*. (pp. 27-55). Washington D.C.: National Academy Press.
- Blumenfeld, W. J. (1992). Squeezed into gender envelopes. In W. J. Blumenfeld (Ed.), *Homophobia: How we all pay the price*. (pp. 23-38). Boston: Beacon Press.
- Boyd, C. O. (1990). Qualitative approaches to research. In G. LoBiondo-Wood & J. Haber (Eds.), *Nursing research: Methods, critical appraisal, and utilization* (2nd ed.). (pp. 181-210). St. Louis: The C. V. Mosby Company.
- Boyd, C. O. (1993). Philosophical foundations of qualitative research. In P. L. Munhall & C. O. Boyd (Eds.), *Nursing research: A qualitative approach* (2nd ed). (pp. 66-94). New York: National League for Nursing Press.
- Bradby, M. (1990). Status passage into nursing: Another view of the process of socialization into nursing. *Journal of Advanced Nursing*, 15(10), 1220-1225.
- Bradley, H. (1993). Across the great divide: The entry of men into "women's jobs". In C. L. Williams (Ed.), *Doing "women's work": Men in nontraditional occupations* (pp. 10-27). Newbury Park CA: Sage Publications, Inc.
- Brady, M. S., & Sherrod, D. R. (2003). Faculty forum: Retaining men in nursing programs designed for women. *Journal of Nursing Education*, 42 (4), 159-162.
- Brink, P. J., & Wood, M. J. (1988). *Basic steps in planning nursing research: From question to proposal* (3rd ed.). Boston: Jones and Bartlett Publishers.
- Brown, R. G. S., & Stones, R. W. H. (1973). *The male nurse: Occasional Papers on Social Administration* 52. London: G. Bell & Sons.

- Buerhaus, P. I., Auerbach, D. I., & Staiger, D. O. (2009). The recent surge in nurse employment: Causes and implications. *Health Affairs – Web Exclusive*, 28(4), w657-668.
- Buerhaus, P. I., Donelan, K., Ulrich, B. T., Norman, L., & Dittus, R. (2005). Is the shortage of hospital registered nurses getting better or worse? Findings from two recent national surveys of RNs. *Nursing Economics*, 23(2), 61-71.
- Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2000a). Implications of an aging registered nurse workforce. *Journal of the American Medical Association*, 283(22), 2948-2954.
- Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2000b). Why are shortages of hospital RNs concentrated in specialty care units? *Nursing Economics*, 18(3), 111-116.
- Bullough, V. L. (1994a). History: Men, women, and nursing history. *Journal of Professional Nursing*, 10(3), 127.
- Bullough, V. L. (1994b). Inquiry, insights, and history: Men in nursing. *Journal of Professional Nursing*, 10(5), 267.
- Burton, D. A., & Misener, T. R. (2007). Are you man enough to be a nurse? Challenging male nurse media portrayals. In C. E. O'Lynn and R. E. Tranbarger (Eds.), *Men in nursing: History, challenges and opportunities* (pp. 255-270). New York: Springer Publishing Company.
- Christman, L. (1988a). Luther Christman. In T. M. Schoor & A. Zimmerman (Eds.) *Making choices, taking chances: Nurse leaders tell their stories*. (pp. 43-52). St. Louis: The C. V. Mosby.
- Christman, L. (1988b). Men in nursing. *Annual review of nursing research*, 6, 193-205.

- Chur-Hansen, A. (2002). Preferences for female and male nurses: The role of age, gender and previous experience-year 2000 compared with 1984. *Journal of Advanced Nursing*, 37(2). Retrieved August, 8, 2008 from <http://web.ebscohost.com/nrc/detail?vid=6&hid=101&sid=321fc067-c66a-49a2-87f3-c486...>
- Clarke, S. P., & Donaldson, N. E. (2008). Nurse staffing and patient care quality and safety. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved July 25, 2009, from www.ahrq.gov/qual/nurseshdbk/docs/ClarkeS_S.pdf
- Clifford, C. (1995). Caring: Fitting the concept to nursing practice. *Journal of Clinical Nursing*, 4(1), 37-41.
- Crabtree, B. F., & Miller, W. L. (1999). Clinical research: A multimethod typology. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed.). (pp. 3-32). Thousand Oakes, CA: Sage Publications, Inc.
- Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (3rd ed.). Upper Saddle River, NJ: Pearson, Merrill, Prentice Hall.
- Creswell, J. W. (1998). *Qualitative inquiry & research design: Choosing among five approaches*. Thousand Oaks, CA: Sage Publications, Inc.
- Creswell, J. W. (2005). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (2nd ed.). Upper Saddle River, NJ: Pearson, Merrill, Prentice Hall.

- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed). Thousand Oaks, CA: Sage Publications.
- Creswell, J., & Miller, D. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124-130.
- Denzin, N. K., & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). (pp. 1-30). Thousand Oaks, CA: Sage Publications, Inc.
- DePoy, E., & Gitlin, L. N. (1998). *Introduction to research: Understanding and applying multiple strategies* (2nd ed.). St. Louis: Mosby.
- Donahue, M. P. (1996). *Nursing: The finest art: An illustrated history* (2nd ed.). St. Louis: Mosby.
- du Toit, D. (1995). A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing*, 21(1), 164-171.
- Dyck, J. M., Oliffe, J., Phinney, A., & Garrett, B. (2009). Nursing instructors' and male nursing students' perceptions of undergraduate, classroom nursing education. *Nurse Educator Today*, 29(6), 649-653.
- Egeland, J. W., & Brown, J. S. (1988). Sex role stereotyping and role strain of male registered nurses. *Research In Nursing*, 11, 257-267.

- Egeland, J. W., Brown, J. S. (1989). Men in nursing: Their fields of employment, preferred fields of practice, and role strain. *Health Services Research, 24*(5), 693-707.
- Epstein, C. F. (1970). Encountering the male establishment: Sex-status limits on women's careers in the professions. *The American Journal of Sociology, 75* (6), 965-982.
- Epstein, C. F. (1989). Workplace boundaries: Conceptions and creations. *Social Research, 56*(3), 571-590.
- Estabrooks, C. A. (1987). Touch in nursing practice: A historical perspective. *Journal of Nursing History, 2*(2), 33-49.
- Evans, J. A. (2002). Cautious caregivers: Gender stereotypes and the sexualization of men nurses' touch. *Journal of Advanced Nursing, 40* (4), 441-448.
- Farrell, W. (2005). *Why men earn more: The startling truth behind the pay gap- and what women can do about it*. New York: American Management Associates.
- Flannery, D. D. (2000). Identity and self-esteem. In E. Hayes & D. D. Flannery (Eds.), *Women as learners: The significance of gender in adult learning*. (pp. 53-78). San Francisco: Jossey-Bass Inc., Publishers.
- Flannery, D. D., & Hayes, E. (2000). Women's learning: A kaleidoscope. In E. Hayes & D. D. Flannery (Eds.), *Women as learners: The significance of gender in adult learning*. (pp. 1-23). San Francisco: Jossey-Bass Inc., Publishers.
- Floge, L., & Merrill, D. M. (1986). Tokenism reconsidered: Male nurses and female physicians in a hospital setting. *Social Forces, 64*(4), 925-947.

- Fottler, M. D. (1976). Attitudes of female nurses toward the male nurse: A study of occupational segregation. *Journal of Health and Social Behavior*, 17 (2), 98-110.
- Freeman, S. J. M. (1990). *Managing lives: Corporate women and social change*. Amherst, MA: University of Massachusetts Press.
- Fry, T. (Ed.). (1980). *The rule of St. Benedict in English*. Collegeville, MN: The Liturgical Press.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Glesne, C. (2006). *Becoming qualitative researchers: An introduction* (3rd ed.). Boston: Pearson, Allyn and Beacon.
- Gray, J. (1992). *Men are from Mars, women are from Venus; A practical guide to improving communication and getting what you want in your relationships*. New York: HarperCollins Publishers, Inc.
- Grbich, C. (1999). *Qualitative research in health: An introduction*. London: Sage Publications.
- Hall, R. M., & Sandler, B. (1982). *The classroom climate: A chilly one for women?* Project on the Status and Education for Women. Washington, D. C., Association of American Colleges.
- Hancock, C. (2000). Stereotypes binned. *Nursing Times*, 96(1), 12-13.
- Hart, K. A. (2005). Survey respondents speak out. *Nursing*, 35 (11), 47-48.
- Hayes, E. (2000). Social contexts. In E. Hayes & D. D. Flannery (Eds.), *Women as learners: The significance of gender in adult learning*. (pp. 23-53). San Francisco: Jossey-Bass Inc., Publishers.

- Hayes, E. (2001). A new look at women's learning. In S. B. Merriam (Ed.), *The new update on adult learning theory*. (pp. 35-42). San Francisco: Jossey-Bass.
- Hek, G., Judd, M., & Moule, P. (1996). *Making sense of research: An introduction for nurses*. New York: Cassell.
- Holstein, J. A., and Gubrium, J. F. (2003). Inside interviewing: New lenses, new concerns. In J. A. Holstein and J. F. Gubrium (Eds.), *Inside interviewing: New lenses, new concerns* (pp. 3-32). Thousand Oaks, CA: Sage Publications, Inc.
- Hoffmann, F. (1991). Feminism and nursing. *National Women's Studies Association*, 3(1), 53-69. Retrieved September 27, 2009 from <http://www.jstor.org/stable/4316105>
- Inoue, M., Chapman, R., & Wynaden, D. (2006). Male nurses' experiences of providing intimate care for women clients. *Journal of Advanced Nursing*, 55(5), 559-567.
- Irwin, L. (2005). Homophobia and heterosexism: Implications for nursing and nursing practice. *Australian Journal of Advanced Nursing*, 25(1), 70-76.
- Jacox, A., Suppe, F., Campell, J. & Stachinko, E. (1999). Diversity in philosophical approaches. In A. S. Hinshaw, S. C. Feetham, & J. L. F. Shaver, (Eds.), *Handbook of clinical nursing research* (pp. 3-17). Thousand Oaks, CA: Sage Publications, Inc.
- Jinks, A. M., & Bradley, E. (2004). Angel, handmaiden, battleaxe or whore? A study which examines changes in newly recruited student nurses' attitudes to gender and nursing stereotypes. *Nurse Education Today*, 24(2), 121-127.
- Kadushin, A. (1976). Men in a woman's profession. *Social Work*, 21(6), 440-447.

- Kalisch, P. A., & Kalisch, B. J. (1978). *The advance of American nursing*. Boston: Little, Brown and Company.
- Kalisch, P. A., & Kalisch, B. J. (1982). The image of nurses in novels. *American Journal of Nursing*, 82(8), 1220-1224.
- Kanter, R. M. (1977). *Men and women of the corporation*. New York: Basic Books, Inc.
- Kauppinen-Toropainen, K. & Lammi, L. (1993). Men in female-dominated occupations: A cross-cultural comparison. In C. L. Williams (Ed.), *Doing "women's work": Men in nontraditional occupations* (pp. 91-112). Newbury Park, CA: Sage Publications, Inc.
- Kelly, N. R., Shoemaker, M., & Steele, T. (1996). The experience of being a male nurse. *Journal of Nursing Education*, 35(4), 170-174.
- Keogh, B., & Gleeson, M. (2006). Caring for female patients: The experiences of male nurses. *British Journal of Nursing*, 15(21), 1172-1175.
- Lawrence, B. (Producer). (2003, January 30). His story [Television series episode]. [With Sarah Chalke, Zach Braff, & Donald Faison, John McGinley, Judy Reyes, Ken Jenkins, & Neil Flynn]. In *Scrubs*. New York: National Broadcasting Company.
- LaRocco, S. A. (2007). Recruitment and retention of men in nursing: A review. In C. E. O'Lynn and R. E. Tranbarger (Eds.), *Men in nursing: History, challenges and opportunities* (pp. 241-270). New York: Springer Publishing Company.
- Laroche, E., & Livneh, H. (1983). Regression analysis of attitudes toward male nurses. *The Journal of Psychology*, 113, 67-71.
- Lerner, D. J., D'Agostino, R. B., Musolino, J., & Malspeis, S. (1994). Breaking with tradition: The new groups in professional nursing. *Medical Care*, 32 (1), 67-80.

- Lewin, K. (1951). Frontiers in group dynamics. In D. Cartwright (Ed.), *Field theory in social science: Selected theoretical papers* (pp. 188-237). New York: Harper Torchbooks.
- Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contraindications, and emerging confluences. In N. K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). (pp. 163-187). Thousand Oaks, CA: Sage Publications, Inc.
- Mackintosh, C. (1997). A historical study of men in nursing. *Journal of Advanced Nursing*, 26(2), 232-236.
- Marks, L. N. (1980). Nursing is not a 'women's profession'. *RN*, 43 (4). Retrieved August 15, 2008, from <http://web.ebscohost.com/nrc/detail?vid=4&hid=101&sid=321fc067-c66a-49a2-87f3-c486...>
- Marshall, H. (2002). What do we do when we code data? *Qualitative Research Journal*, 2 (1), 56-70.
- Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Meadus, R. J. (2000). Men in nursing: Barriers to recruitment. *Nursing Forum*, 35 (3), 5-12.
- Meadus, R. J., & Twomey, J. C. (2007). Men in nursing: Making the right choice. *Canadian Nurse*, 103 (2), 13-16.
- Mellish, J. M. (1990). *A basic history of nursing* (2nd ed.). Durban: Butterworths.
- Merton, R. (1968). *Social theory and social structure*. New York: The Free Press.

- Mickelson, R. A. (1989). Why does Jane read and write so well? The anomaly of women's achievement. *Sociology of Education*, 62 (1), 47-63.
- Milligan, F. (2001). The concept of care in male nurse work: An ontological hermeneutic study in acute hospitals. *Journal of Advanced Nursing*, 35(1). Retrieved August 15, 2008 from <http://web.ebscohost.com/nrc/detail?vid=8&hid=104&sid=4a205af2-f8e9-4312-93fb-5b45...>
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Muldoon, O. T., & Reilly, J. (2003). Career choice in nursing students: Gendered constructs as psychological barriers. *Journal of Advanced Nursing*, 43(1), 93-100.
- Mulherin, D. (2007). Another perspective on men in nursing. *Journal of Nursing Education*, 46(6), 249.
- Munhall, P. L. (1994). *Revisioning phenomenology: Nursing and health science research*. New York: National League for Nursing Press.
- Murray, M. K. (2002). The nursing shortage: Past, present, and future. *The Journal of Nursing Administration*, 32 (2), 79-84.
- Myers, M. D. (1997). *Qualitative Research in Information Systems*. Association for Information Systems. Retrieved August 4, 2008, from <http://www.qual.auckland.ac.nz/>
- Newman, R. (2000). *A fool in love* [CD]. Universal City, CA: Dreamworks Records.
- Nightingale, F. (1969). *Notes on nursing: What it is and what it is not*. New York: Dover Publications, Inc. (Original work published 1860).

Nurses station: Distinctive gifts for the nursing profession. (Spring 2009 catalogue).

Retrieved July 29, 2009 from <http://www.nursesdirect.com/>

Nutting, M. A., & Dock, L. L. (1974). *A history of nursing: The evolution of nursing systems from the earliest times to the foundation of the first English and American training schools for nurses*. (Vols. 1-2), Buffalo, NY: The Heritage Press.

(Original work published 1907).

O'Lynn, C. E. (2004). Gender-based barriers for male students in nursing education programs: Prevalence and perceived importance. *Journal of Nursing Education*, 43 (5), 229-236.

O'Lynn, C. E. (2007a). History of men in nursing: A review. In C. E. O'Lynn and R. E. Tranbarger (Eds.), *Men in nursing: History, challenges and opportunities* (pp. 5-42). New York: Springer Publishing Company.

O'Lynn, C. E. (2007b). Men, caring and touch. In C. E. O'Lynn and R. E. Tranbarger (Eds.), *Men in nursing: History, challenges and opportunities* (pp. 121-142). New York: Springer Publishing Company.

O'Lynn, C. (2009). Who is in need of socialization? *Nursing Education*, 48(4), 179-180.

Okrainec, G. (1990). The views of male nursing students. *The Canadian Nurse*, 86(5), 14-15.

Parse, R. R. (2001). *Qualitative inquiry: The path of sciencing*. Sudbury, MA: Jones and Bartlett Publishers.

Patterson, B. J., & Morin, K. H. (2002). Perceptions of the maternal-child clinical rotation: The male student nurse experience. *Journal of Nursing Education*, 41(6), 266-272.

- Paterson, B. L., Tschikota, S., Crawford, M., Saydak, M., Venkatesh, P., & Aronowitz, T. (1996). Learning to care: Gender issues for male nursing students. *Canadian Journal of Nursing*, 28(1), 25-39.
- Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions for the twenty-first century*. San Francisco: University of California, San Francisco, Center for the Health Professions.
- Pittman, E. (2005). *Luther Christman: A maverick nurse – A nursing legend*. Victoria, BC Canada: Tafford.
- Poliafico, J. (1998). Nursing's gender gap. *RN*, 81(10), 39-42.
- Porter-O'Grady, T. (2007). Reverse discrimination in nursing leadership: Hitting the concrete ceiling. In C. E. O'Lynn and R. E. Tranbarger (Eds.), *Men in nursing: History, challenges and opportunities* (pp. 143-152). New York: Springer Publishing Company.
- Pringle, R. (1989). *Secretaries talk: Sexuality, power and work*. London: Verso.
- Reskin, B. F., & Hartmann, H. I. (1986). *Women's work, men's work: Sex segregation on the job*. Washington D. C.: National Academy Press.
- Roach, J. (Director). (2000). *Meet the parents* [Motion picture.]. [With Robert De Niro & Ben Stiller]. United States: Universal Studios and Dreamworks LLC.
- Roach, J. (Director). (2004). *Meet the Fockers* [Motion picture.]. [With Robert De Niro, Ben Stiller, Dustin Hoffman, & Barbara Streisand]. United States: Universal Studios and Dreamworks LLC.

- Roosevelt, F. D. (1945). State of the union address. Retrieved July 25, 2009 at <http://www.presidency.ucsb.edu/ws/index.php?pid=16595>
- Roth, J. E., & Coleman, C. L. (2008). Perceived and real barriers for men entering nursing: Implications for gender diversity. *Journal of Cultural Diversity*, 15(3), 148-152.
- Segal, B. E. (1962). A case study in status contraindication and prestige loss. *Social Forces*, 41 (1), 31-38.
- Seidel, J.V., & Clark, J. A. (1984). The ethnograph: A computer program for the analysis of qualitative data. *Qualitative Sociology*, 7(1/2), 110-125.
- Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.). Columbia University, NY: Teachers College Press.
- Sherrod, B., Sherrod, D., & Rasch, R. (2005). Men at work. *Nursing Management* 36(10), 46-51.
- Simpson, R. (2004). Masculinity at work: The experience of men in female dominated occupations. *Work, Employment, and Society*, 18(2), 349-368.
- Simpson, R. (2005). Men in non-traditional occupations: Career entry, career orientation and experience of role strain. *Gender, Work, and Organization*, 12(4), 363-380.
- Smith, J. J. (2006). Exploring the challenges for nontraditional male students transitioning into a nursing program. *Journal of Nursing Education*, 45(7), 263-269.

- Snape, D., & Spencer, L. (2003). The foundations of qualitative research. In J. Ritchie and J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 1-23). London: Sage Publications.
- Spader, C. (2009). Horray for Hollywood. *NurseWeek*, 10(1), 30-31.
- Stott, A. (2004). Issues in the socialisation process of the male student nurse: Implications for retention in undergraduate nursing courses. *Nurse Education Today*, 24(2), 91-97.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. Cambridge, NY: Cambridge University Press.
- Streubert, H. J. (1994). Male nursing students' perceptions of clinical experience. *Nurse Educator*, 19(5), 28-32.
- Sochalski, J. (2002). Nursing shortage redux: Turning the cover on an enduring problem. *Health Affairs*, 21(5), 157-162.
- Spratley, E., Johnson, A., Sochalski, J., Fritz, M., & Spencer, W. (2000). The registered nurse population: Findings from the national sample survey of registered nurses. *U. S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions, Division of Nursing*. Retrieved July 16, 2009, from <http://bhpr.hrsa.gov/healthworkforce/reports/rnsurvey/default.htm>
- Tahnmincioglu, E. (2003, April 13). Men are much in the sights of recruiters in nursing. *The New York Times*. Retrieved July 29, 2009, from www.nytimes.com/2003/04/13/jobs/13JMAR.html

- Taylor, S. J., & Bogdan, R. (1998). *Introduction to qualitative research methods* (3rd ed.). New York: John Wiley & Sons, Inc.
- Tejeda, M. J. (2004). Egalitarianism and self-esteem as correlates of hate ideation against gay men and lesbians. *The Journal of Multicultural Nursing & Health*, 10(1), 42-50.
- Tisdell, E. J. (2000). Feminist pedagogies. In E. Hayes & D. D. Flannery (Eds.), *Women as learners: The significance of gender in adult learning*. (pp. 155-184). San Francisco: Jossey-Bass Inc., Publishers.
- Tranbarger, C. E. (2007). American schools for men. In C. E. O'Lynn and R. E. Tranbarger (Eds.), *Men in nursing: History, challenges and opportunities* (pp. 43-66). New York: Springer Publishing Company.
- United States Department of Health and Human Services Health Resources and Services Administration. (2004). The registered nurse population: Findings from the 2004 national sample. Retrieved July 15, 2009, from <http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/>
- United States Department of Labor Women's Bureau. (2006). 20 leading occupations of employed women 2006 annual averages. Retrieved July 15, 2009, from <http://www.dol.gov/wb/factsheets/20lead2006.htm>
- United States Department of Labor Women's Bureau. (2008a). Employment status of women and men in 2008. Retrieved July 16, 2009, from <http://www.dol.gov/wb/factsheets/Qf-ESWM08.htm>

- United States Department of Labor Women's Bureau. (2008b). Quick stats on women workers, 2008. Retrieved July 15, 2009, from <http://www.dol.gov/wb/stats/main.htm>
- United States Department of Labor Women's Bureau. (2008c). 20 leading occupations of employed women 2008 annual averages. Retrieved July 16, 2009, from <http://www.dol.gov/wb/factsheets/20lead2008.htm>
- Weber, D. (2008). Finding their niche: Why men choose nursing. *RN*, 71 (2), 34-39.
- Wharton, A. S., & Baron, J. N. (1987). So happy together? The impact of gender segregation. *American Sociological Review*, 52(5), 574-587.
- Whittock, M., & Leonard, L. (2003). Stepping outside the stereotype. A pilot study of the motivations and experiences of males in the nursing profession. *Journal of Nursing Management*, 11(4), 242-249.
- Williams, C. L. (1992). The glass escalator: Hidden advantages for men in the "female" professions. *Social Problems*, 39(3), 253-267.
- Williams, C. L., & Heikes, E. J. (1993). The importance of researcher's gender in the in-depth interview: Evidence from two case studies of male nurses. *Gender and Society*, 7(2), 280-291.
- Williams, L. S., & Villemez, W. J. (1993). Seekers and finders: Male entry and exit in female-dominated jobs. In C. L. Williams (Ed.), *Doing "women's work": Men in nontraditional occupations* (pp. 64-90). Newbury Park CA: Sage Publications, Inc.
- Williams, R. A. (1973). Characteristics of male baccalaureate students who selected nursing as a career. *Nursing Research*, 22(6), 520-525.

Witz, A. (1992). *Professions and patriarchy*. London: Routledge.

Yoshimura, C. G., & Hayden, S. E. (2007). The effects of gender on communication and workplace relations. In C. E. O'Lynn and R. E. Tranbarger (Eds.), *Men in nursing: History, challenges and opportunities* (pp. 103-120). New York: Springer Publishing Company.

Zimmerman, M. K., & Hill, S. A. (1999). Health care as a gendered system. In J. S. Chafetz (Ed.), *Handbooks of sociology and social research* (483-518). New York: Kluwer Academic/Plenum Publishers.